St. Bartholomew's Hospital

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

JOURNAL.

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CALENDAR.

Thurs., Mar.	1.	**Inter-Hospitals Rugby Cup. Semi-final. Bart.'s *v.* St. Thomas's Hospital.**
Fri., ,,	2.	Medicine: Clinical Lecture by Dr. Graham. Dr. Hinds Howell and Mr. Harold Wilson on duty.
Sat., ,,	3.	Rugby Match *v.* Mosely. Home. Association Match *v.* Emmanuel College, Cambridge. Home. Hockey Match *v.* St. Lawrence College. Away.
Mon., ,,	5.	Special Subject: Clinical Lecture by Mr. Bedford Russell.
Tues., ,,	6.	Dr. Gow and Mr. Girling Ball on duty.
Wed., ,,	7.	Surgery: Clinical Lecture by Mr. Harold Wilson.
Fri., ,,	9.	Medicine: Clinical Lecture by Dr. Hinds Howell. Dr. Graham and Mr. Roberts on duty.
Sat., ,,	10.	Rugby Match *v.* Devonport Services. Home. Association Match *v.* Brighton Old Grammarians. Home. Hockey Match *v.* Reading University. Away.
Mon., ,,	12.	Special Subject: Clinical Lecture by Mr. Just.
Tues., ,,	13.	Prof. Fraser and Prof. Gask on duty.
Wed., ,,	14.	**Annual General Meeting—Students' Union.** Surgery: Clinical Lecture by Mr. Girling Ball.
Fri., ,,	16.	Lorder Horder and Sir Charles Gordon-Watson on duty.
Sat., ,,	17.	Association Match *v.* London Welsh. Away. Hockey Match *v.* Oxford Occasionals. Home.
Tues., ,,	20.	Dr. Hinds Howell and Mr. Harold Wilson on duty. **Last day for receiving matter for the April issue of the Journal.**
Fri., ,,	23.	Dr. Gow and Mr. Girling Ball on duty.
Sat., ,,	24.	Rugby Match *v.* Pontypool. Away. Association Match *v.* Southgate Wanderers. Away. Hockey Match *v.* Gravesend. Home.
Tues., ,,	27.	Dr. Graham and Mr. Roberts on duty.
Fri., ,,	30.	Prof. Fraser and Prof. Gask on duty.
Sat., ,,	31.	Association Match *v.* Old Carthusians. Home. Hockey Match *v.* Harlesden. Away.

EDITORIAL.

WE have heard rumours that there is a movement afoot for the abolition of medical consultations.

The system of "consultations", which is unique at Bart.'s, was begun about 1860, and Sir D'Arcy Power traced their origin to the old method of the Middle Ages, by which a surgeon having under his care a patient in danger of death or maim was held blameless if he had shown the case to the Governing Members of his craft within three days of the injury, whilst he was liable to fine and imprisonment if he had failed to do so. It was with regret that we received the news of the proposed ousting of "consultations", and we hope that those in whose hands their eventual fate depends will be wise enough to turn down the suggestion not only because of the tradition of these weekly gatherings, but because of their value in mingling together the ideas of extensive experience

The moments spent on Thursday afternoons listening to the oral combat between the glib tongues of the Senior Staff has long been regarded as the most entertaining of a week's hospital life; students learn that even their teachers may differ amicably, and that no human being is constituted to know the truth, the whole truth, and nothing but the truth. May Bart.'s long remain unique in a few of her time-honoured customs.

* * *

COLLEGE APPEAL.

We have received the following letter:

To the Editor, 'St. Bartholomew's Hospital Journal'.

"THE HOLT,
"EYNSHAM,
"OXFORD;
"*February 18th*, 1934.

"DEAR SIR,—On referring to the figures of the College Appeal Fund in the JOURNAL for February, 1934, I find, if my arithmetic is correct, that out of 3065 old students resident in London and the Counties, only 774, or approximately one-quarter, have so far responded to the Appeal for their old Medical School.

"There are, no doubt, a considerable number who have lost all interest, but from my experience as an Honorary County Secretary, I feel convinced that there are also a very large number of men who, in these hard times, cannot afford to give what they consider an adequate sum, yet feel reluctant to send a lesser amount. To these I would suggest that they may be able, if they so wish, to make up the full amount of their desire later on, but that even a very small contribution would be welcomed *now* in order that the world may know that at least the half of her old students have rallied to the support of their *Alma Mater*. It is the will to help by *all* old students, and not only the amount given, that is of value and adds to the prestige of Bart.'s.

"Again, there are many on the retired list, who, with responsibilities incurred in easier times, are unable with restricted incomes to contribute as they would wish, under present circumstances, but after making adequate provision for their dependents, might feel disposed at their deaths, or the death of a dependent, to leave a legacy. It only means a short codicil to a will, or the filling up of a legacy form, either of which could be revocable in case of need.

"It must be many years, in spite of the business capacity and energy of our Dean, super-beggar though he be, before the whole of the outstanding debt is paid off, and the equipment of the buildings completed, and what more welcome than from time to time to have unexpected sums coming in when the enthusiasm of the first Appeal is waning?

"I would suggest this point of view more especially to all confirmed bachelors, and also to all old Bart.'s men who, having passed the grand climacteric, are beginning to feel stiff in the joints, and whose scalps afford a ready jest for contemporary club convivialists.

"In this way they would still be doing something for their old Medical School, and the good they do will 'live after them', and not be 'interred with their bones'.

"I am, Sir,
"Yours, etc.,
"JOHN A. HAYWARD."

* * *

The Dean writes:

"*February 21st*, 1934.

"DEAR SIR,—My letter in your last issue promised a more detailed account of the position of the Appeal.

"As your readers know, the sum required to complete the purchase of the Site from the Merchant Taylors' Company is £130,000. Donations received and promised amount to £56,500. College funds available for the purpose amount to £9000, and we have a building (No. 6, Giltspur Street) which is valued at £20,000. These items total £85,500. We are, therefore, well over the halfway line ('Square 3'!), and vigorous and concerted action should result in a try 'under the posts'. But all this money is not immediately available. Payment of much of it is spread over a number of years, and the building in Giltspur Street cannot be sold until we are able to equip those in Charterhouse Square.

"Of the money accruing from our public appeal we are permitted by the Company to reserve a portion (up to £17,000) for the re-equipment of the buildings in Charterhouse Square. Towards this sum we have so far collected about £7000 only. We urgently need £25,000 to enable us to vacate the building in Giltspur Street. We intend, therefore, to make another determined 'push' now; first, by appealing to old 'Bartholomew's men to help us still further; and, secondly, through the assistance of the Lord Mayor of London, who, we have reason to believe, is going to help us.

"With regard to the old Bart.'s men themselves, there are over 3000 on the Register, and it is just a little disappointing that only one in every four of them has subscribed. The efforts of those who have subscribed have been magnificent. But we do feel that, among the many who have as yet made no response to our appeals, there are more than a few who could help if they would.

"If there are some who, though unable to give now, are willing to do so in the future, will they not write to me and say so? Such promises of future help, whether next year or a few years hence, or even by legacy, would be a great encouragement.

"With regard to Dr. Young's letter, I am glad to say that I now have four of the requisite five undertakings to give 25 guineas per annum for five years. Is there not one other? I feel sure that Dr. Young would permit the spreading of the amount over a longer number of years provided the total sum was the same, viz., 125 guineas.

"Yours sincerely,
"W. GIRLING BALL,
"*Dean of the Medical College*."

* * *

COLLEGE APPEAL FUND.

	£	s.	d.		†
Staff	12,321	5	9	(71)	
Demonstrators	1,674	11	0	(67)	
Students	660	2	3	(282)	
Old Bart.'s men:					
Bedfordshire	10	10	6	(2)	(26)
Berkshire	96	1	0	(14)	(37)
Buckinghamshire	74	19	0	(13)	(29)
Cambridgeshire	165	14	0	(13)	(42)
Carried forward	£15,003	3	6		

	£	s.	d.		
Brought forward. . .	15,003	3	6		
Cheshire	1	1	0	(1)	(26)
Cornwall	22	2	0	(5)	(36)
Cumberland	5	0	0	(1)	(6)
Derbyshire	19	14	0	(4)	(17)
Devonshire	543	0	0	(50)	(117)
Dorset	52	1	0	(14)	(30)
Durham	16	6	0	(3)	(11)
Essex	229	19	6	(17)	(69)
Gloucestershire . . .	218	12	6	(20)	(66)
Hampshire	406	14	0	(38)	(134)
Herefordshire	13	3	0	(4)	(11)
Hertfordshire	73	0	0	(12)	(73)
Huntingdonshire . . .					(1)
Isle of Wight	181	13	0	(12)	(25)
Kent	558	3	0	(64)	(146)
Lancashire	91	2	0	(11)	(82)
Leicestershire . . .	133	12	0	(6)	(28)
Lincolnshire	47	6	0	(13)	(25)
Middlesex	382	3	0	(18)	(68)
Norfolk	159	7	6	(18)	(60)
Northamptonshire . . .	54	4	0	(4)	(17)
Northumberland . . .	101	1	0	(2)	(11)
Nottinghamshire . . .	13	13	0	(2)	(28)
Oxfordshire	180	3	0	(17)	(29)
Rutland					(2)
Shropshire	35	9	0	(8)	(22)
Somersetshire. . . .	463	10	0	(26)	(43)
Staffordshire	194	18	0	(6)	(37)
Suffolk	263	1	0	(16)	(46)
Surrey	425	12	6	(44)	(180)
Sussex	266	1	0	(46)	(170)
Warwickshire . . .	177	0	6	(17)	(56)
Westmorland	1	0	0	(1)	(5)
Wiltshire	97	11	0	(11)	(26)
Worcestershire . . .	148	14	6	(20)	(27)
Yorkshire	270	4	6	(21)	(101)
Wales	46	4	0	(10)	(150)
London	2,733	2	8	(174)	(971)
Channel Islands . . .	10	0	0	(1)	(9)
Scotland	14	4	0	(4)	
Abroad	48	5	0	(7)	
South Africa	326	10	6	(17)	
Canada	113	2	6	(8)	
East Africa	62	7	0	(6)	
West Africa	146	10	0	(5)	
India	152	0	0	(7)	
Ceylon	4	0	0	(1)	
Syria	2	2	0	(1)	
U.S.A.	5	0	0	(1)	
Ireland	14	14	0	(3)	
North Africa	1	0	0	(1)	
North Borneo . . .	5	5	0	(1)	
Australia	12	2	0	(3)	
Egypt	4	2	0	(2)	
Malay States	6	0	0	(2)	
China	45	7	4	(7)	
Siam	10	0	0	(1)	
France	50	0	0	(1)	
Trinidad	22	2	0	(2)	
British West Indies . .	23	1	0	(3)	
Kenya	10	0	0	(2)	
New Zealand	2	1	0	(2)	
Services.	514	14	0	(33)	
Others	31,479	15	7	(266)	
	£56,712	17	7		

† Number of Bart.'s men in County.

Readers will be interested to learn that the following gentlemen have been made Governors of the Medical College for their services to the College in connection with the Appeal:

Sir Charles Collett, Lord Mayor of the City of London.
Sir Milsom Rees.
Mr. Barry Mason.
Mr. Geoffrey Vigers.
Sir George Wilkinson, Alderman.
The Masters of the Merchant Taylors' Company and the Mercers' Company.

The following old St. Bartholomew's men have also been made Governors of the College in recognition of their efforts in stimulating the Bart.'s men in their respective counties to subscribe to the Fund:

Mr. Ransom Pickard.
Dr. E. J. Toye.
Dr. J. A. Hayward.
Dr. A. R. Neligan.
Mr. E. M. Atkinson.

* * *

We would draw attention to a letter in the correspondence columns written by Dr. Garrod. The letter emphasizes the value of determining the existence of unmasticated food in the fæces—a procedure which may be carried out without expense or trouble, and which may throw light on many supposed gastro-intestinal conditions.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The Nursing Times—The Cambridge Medical Society Magazine—Charing Cross Hospital Gazette—Guy's Hospital Gazette—St. George's Hospital Gazette—Middlesex Hospital Journal—Queen's Medical Magazine—St. Mary's Hospital Gazette—St. Thomas's Hospital Gazette—The Student—University College Hospital Magazine—King's College Hospital Gazette—Clinical Journal—East African Medical Journal—The British Journal of Venereal Diseases—The General Practitioner—The Hospital—Bulletins et Mémoires de la Société Médécine de Paris—L'Echo Médical du Nord—The Medical Forum—The Medical Press and Circular—Medical Times and Long Island Medical Journal—Post-graduate Medical Journal—Reale Società Italiana D'Igiene—Revue Belge des Sciences Médicales—Archives Hospitalières.

PROGRESS IN RECTAL SURGERY.*

THE path of the student in medical science is like that of the girl in the *Arabian Nights*, whose safety and success depended upon her ascending a stony hill without looking back, pouring a little water upon every stone as she ascended, disregarding all the inducements to turn round which were offered by a chorus of mocking voices behind her.

What a tribute we owe to the masters of surgery who have preceded us in the ascent of the stony hill, and who, by the water they have poured on the stones, have made our path easier.

It may perhaps be permitted to me, after thirty-five years in practice, to glance back at the advancing stream of medical science, to recall some of the glittering bubbles that have floated on the surface, only to burst and disappear. To note, perhaps, some of the refuse that it has cast up on the banks, and to try and catch some inspiration from the passing stream as it pursues its beneficent course, leaving, alas! some of us older ones behind.

ST. MARK'S HOSPITAL AND FREDERICK SALMON.

London is the only city in the world which possesses hospitals devoted exclusively to the treatment of rectal diseases. For this we owe a debt of gratitude to Frederick Salmon, the founder of St. Mark's Hospital. Salmon was a Bartholomew's man, who qualified three years after the battle of Waterloo. Just on a hundred years ago, in 1835, Salmon founded an institution in Aldersgate Street with 7 beds for the relief of the poor afflicted with fistula and other diseases of the rectum, and with the Lord Mayor as the first President.

This was the beginning of St. Mark's Hospital, which in 1854 was finally established in the City Road, and now has 72 beds.

Out of 131 cases admitted in that first year, there were 34 cases of stricture and 26 cases of piles.

Nearly a hundred years later, out of 885 admissions there were 349 cases of hæmorrhoids and only 9 cases of non-malignant stricture. In the progress of rectal surgery, with the elimination of sepsis, non-malignant stricture has become a comparatively rare complaint.

Salmon was the pioneer of modern rectal surgery in England. His operation for hæmorrhoids, known as the Salmon operation, is but little changed to-day, and he was the first surgeon to combine ligature with excision, and, indeed, to settle the controversy of that time between ligature and excision. In his book entitled *Practical Observations on Prolapse of the Rectum* he explains his reasons for advocating this method. These reasons remain sound and practical to-day.

In recent years the injection treatment of hæmorrhoids in selected cases has become firmly established, and in this connection it is of interest to record that the operations for uncomplicated hæmorrhoids at St. Mark's in the ten years 1921–1930 were reduced from 328 to 156 per annum, though the number of new out-patients was increased from 1269 in 1921 to 1962 in 1930.

It is worth noticing, also, that since 1931 the number of operations for hæmorrhoids has again been on the up grade, which rather suggests that the pendulum has been swinging too far in the direction of injections. Nevertheless, the time saved for patients and the beds saved for more urgent cases represent real progress. I will show you a portrait of Salmon, a sketch of his operation for hæmorrhoids, and presently the out-patients' room at St. Mark's as it exists to-day, with three examination cubicles and corresponding dressing cubicles leading into them.

The out-patient attendance at the present day is over 10,000 per annum.

The two hospitals for rectal diseases, St. Mark's and the Gordon, are staffed by general surgeons. In this country we have no pure proctologists. In America there are, in all the big cities, surgeons who devote themselves entirely to specialism in proctology, yet there are no special rectal hospitals in the States.

I am convinced that in both directions our system is the better one. On the one hand, a surgeon engaged in rectal surgery must be an expert abdominal surgeon, and for maximum efficiency must be experienced in all branches of abdominal work, and on the other, success in rectal work depends a good deal on post-operative nursing, which requires a special training not easily obtained in a general hospital.

FISTULA IN ANO.

Some of the earliest records of rectal disease are concerned with fistula *in ano*, and instruments for the cure of this disease have been unearthed at Pompeii.

John Arderne, who practised surgery in the fourteenth and early fifteenth centuries, wrote a treatise on this subject, which was published in the year that the Black Prince died, and I will shortly show you on the screen how he operated for fistula, and also some of the instruments he used.

Arderne must have been far ahead of his time. He favoured cutting through the main track of the fistula with one clean cut into the bowel and allowing the wound to granulate. He did not use caustics or cautery

* The Purvis Oration delivered at the West Kent Medical Society, December 8th, 1933.

as was the practice in those days. Later writers favoured the gradual process of cutting through the track with a ligature.

In Hume's *History of England* it is stated that Henry V, who died in 1422 at the age of 35, died from the effects of a fistula, "which surgeons at that time had not the skill to cure". In so short a time had Arderne's principles and practice been forgotten!

The reign of Louis XIV must have been a golden age for the rectal surgeon. Louis was operated on for fistula, and the surgeon received a fee of £6000, seven other surgeons present were liberally rewarded, and the

Fig. 1.—A Fourteenth Century Surgeon Operating for Fistula in Ano.
(*By permission of Sir D'Arcy Power.*)

apprentice who carried the buckets received £200! History records that after the king's operations fistula became a fashionable disease. Has not history repeated itself in our day in the case of appendicitis.

I will show a sketch of the bistoury used on the King, as depicted by Esmarch.

Shakespeare seems to have been aware of the difficulties of curing a fistula. In *All's well that Ends Well* we find the following conversation:

The Countess inquires of the King's health: "What hope is there of His Majesty's amendment?" and receives the following reply:

"He hath abandoned his physician, Madam; under whose practices he has persecuted time with hope; and finds no other advantage in the process, but only the losing of hope by time."

"What is it, my good lord, the King languishes of?"

And the good lord replies, "A fistula".

Though methods have been polished and refined, the principles of treatment for fistula, which John Arderne advocated in the fourteenth century and Percival Pott in the eighteenth, stand firm in the twentieth century to-day. Can we say this of any other branch of surgery?

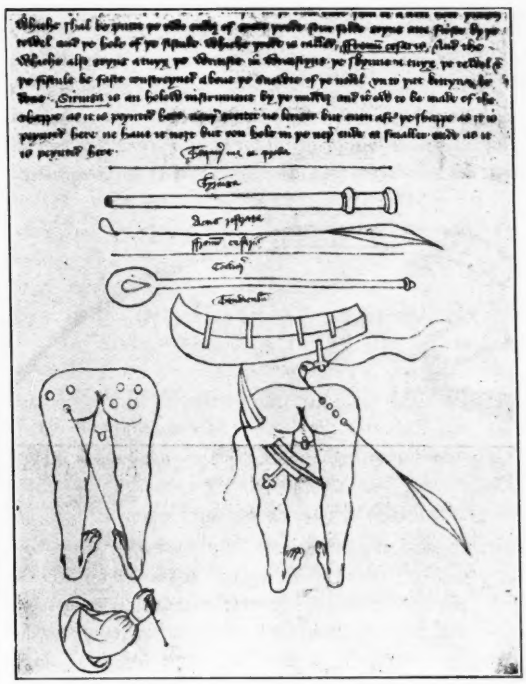


Fig. 2.—John Arderne's Instruments for Fistula.
(*By permission of Sir D'Arcy Power.*)

Percival Pott, who was surgeon to St. Bartholomew's in the latter part of the eighteenth century, published a work on fistula *in ano*, which demonstrates clearly the principles which underlie successful treatment.

Pott advocated simple division of the sphincter, with careful packing of the wound, and, like John Arderne, eschewed all pastes, escharotics and the like, which caused considerable pain and interfered with healing.

In speaking of the quacks of his time and their pastes and balsams, he says: "The business of *good* surgery is to assist Nature, but Nature will sometimes get the better even of the *worst*."

ORIGIN OF FISTULA.

In the study of ano-rectal infections the ætiology of some of the chronic fistulæ, which often seem to have been chronic from the first, has long been obscure. Some daylight has been shed by Dr. Dukes, pathologist to St. Mark's Hospital, by the attention he has drawn to the presence of ano-rectal glands. Although these glands had been described by Hermann and Desfosses as long ago as 1880, and their possible relation to fistula *in ano* hinted at, little use seems to have been made of this discovery.

These glands are tubular branched structures, lined with transitional epithelium, which are situated near the lower end of the anal canal, and they probably represent mucous glands of the primitive cloaca, which have undergone progressive diminution in their distribution, while ascending the animal scale. They may be met with in the substance of the internal

FIG. 3.—THE "ROYAL BISTOURY" WITH WHICH LOUIS XIV WAS OPERATED ON.

sphincter, and are sometimes found passing deep to the sphincter into the ischio-rectal fossa. Should these glands persist in adult life and communicate with the anal canal, as they do in fœtal life and in lower animals, they might well be concerned with infection in the ischio-rectal fossa. These glands are constant in lower animals, vestigial and usually ductless in man.

It has been suggested that their function in lower animals is concerned with sex attraction, and that they act as smell-glands, a function which may have been useful to man before he reached his present high estate. Seeing how much more common fistula is in men than women, it would be of great interest if it could be shown that these glands were more often found in men than in women.

I have been fortunate in finding clinical evidence which supports the theory that a *duct leading to one of these glands can be responsible for an abscess and fistula.*

In a recent early acute abscess I found a direct communication between abscess and anal canal passing through the external sphincter. I dissected out this track and found that it was lined with transitional epithelium similar to that of the ano-rectal glands, which strongly suggests that the abscess started in one of these glands which possessed a duct leading into the anal canal.

I will show you slides illustrating these ano-rectal glands, and a section showing the lining of the track leading to the ischio-rectal abscess in the case I have referred to.

CANCER OF THE RECTUM.

In Holmes's *System of Surgery*, the standard work of the day, published some sixty years ago, we find the following:

"The treatment to be adopted for malignant disease of the rectum can offer no other service than that of palliating the disease, assuaging pain and prolonging the duration of life. . . .

"Some surgeons were, a few years since, in the habit of performing excision of the lower part of the rectum when affected with cancer; but this proceeding must be looked upon as both barbarous and unscientific, and it is now happily exploded from the catalogue of surgical operations."

This was the feeling in England at that time despite the fact that some forty years previously, in 1830, Lisfranc had delivered an illuminating paper at the Royal Academy of Medicine in Paris on the treatment of rectal cancer by extirpation.

In 1877 Harrison Cripps, Surgeon to St. Bartholomew's, was awarded the Jacksonian prize for his essay entitled, "The Possibility of Cure or Relief of Cancer of the Rectum by Excision", and it was, I think, in some measure due to him that excision of the rectum for cancer became popularized and better recognized as a legitimate and rational procedure in this country, despite the fact that Sir James Paget, who was regarded as the greatest living authority of his day on cancer, had expressed the view that "the number of cases in which cancer does not recur after operation is not one in five hundred".

Twenty-five years ago, in my Presidential Address to the Æsculapian Society, I made a plea for placing the treatment of cancer of the rectum on the same plane as the radical treatment of cancer of the tongue and breast. This rational line of treatment is now happily established, though the methods, adopted to secure it, vary.

We all recognize that in our efforts to cure cancer of the rectum we have made considerable progress in the last quarter of a century, and I could hardly illustrate this better than by reference to the beautiful technique of the abdomino-perinæal excision as exemplified by

Miles, or, indeed, to the perinæal method of Lochhart-Mummery. I will presently illustrate a specimen removed by the operation which perhaps may become the most popular of all—the perinæo-abdominal.

Improvements in radiological technique have been responsible for the earlier recognition of growths, especially those involving the sigmoid above the reach of the sigmoidoscope, and the importance of an oblique picture in doubtful cases is now well recognized.

It must perhaps still be regarded as a reproach to surgery that the radical treatment of cancer of the rectum involves a permanent colostomy. Harrison Cripps practised excision from the perinæum without a colostomy, only excising as much of the bowel as was necessary to get clear of the growth, leaving an anus which was devoid of sphincteric control. His statistics, both as regards mortality and recurrence, were remarkably good.

Grey Turner has been very successful *in selected cases* in carrying out resection of a segment of the rectum with anastomosis, preserving the sphincters, and the statistics of his end-results are excellent. He has published records of 7 cases who have survived more than six years following conservative resection in 15 cases of cancer of the rectum. This method, which is ideal for *early* growths in the mid-rectal region, has unfortunately only a limited sphere of usefulness.

In 1925 and succeeding years I began to treat cases of carcinoma of the rectum with interstitial radium, combined with the surgery of access, hoping that I might develop a technique which would, in favourable cases, avoid the stigma of colostomy. Prolonged experience has shown, however, that the technical difficulties, in order to secure a perfect irradiation are very great, and the results, despite a few brilliant successes, very uncertain owing to the fact that adeno-carcinomata vary considerably in radio-sensitivity.

I now relegate the use of radium to certain borderline cases with a view to rendering them operable, to early cases of epithelioma of the anus, and to operable growths of the rectum when radical surgery is *contra-indicated on general grounds.*

I will show some slides illustrating the successful treatment of epithelioma of the anus with radium in a man over 70.

In the after-treatment of severe operations like excision of the rectum we have made notable progress. The use of spinal anæsthesia has helped to diminish shock and to diminish post-operative pulmonary complications.

The excellent facilities for blood transfusion with a simplified technique have undoubtedly reduced mortality. Urinary complications, which, in the past, have often been responsible for fatal complications, have steadily diminished with the introduction and use of the St. Mark's apparatus, which enables the catheter to be kept sterile.

Origin of Cancer of the Rectum.

Thanks to the work of Cuthbert Dukes we have learnt much about the genesis of cancer of the rectum, and can trace the stages from hyperplasia to adenoma, adenoma to carcinoma in such convincing fashion that we now regard this sequence of events as clear-cut and established. We know, too, that multiple adenomatosis of the colon is a disease which runs in families, and that these families tend to die out. Cuthbert Dukes has traced the family histories of afflicted patients, and shown how many members of the family succumb to polyposis or malignant disease of bowel. The majority of those who suffer from this complaint either die of hæmorrhage or succumb to carcinoma of the bowel. Some few have been saved by complete colectomy.

Harrison Cripps seems to have been the first to recognize that multiple polyposis of the colon was a disease "*sui generis*", and he recorded two cases in brother and sister. Five years later Sir Thomas Smith (then Mr. Smith) described three cases occurring in one family, but it was not till 1890, when Handford described a case of intestinal polyposis in a woman of 34, who died of cancer of the rectum, that the association of polyposis with malignant disease was recognized. In 36 recorded cases of polyposis intestini in which the cause of death was known, 21 were known to have died of carcinoma of the bowel.

The presence of scattered adenomata, or the occurrence of successive adenomata, following removals is an indication that the mucosa generally of the particular rectum concerned is *potentially malignant.* A small isolated adenoma on removal may show early malignant change, or one of many adenomata may become malignant. The local removal of this malignant adenoma may be followed by the development of malignancy in another adenoma, and occasionally more than one malignant tumour may co-exist with multiple adenomata.

In many instances a rectal carcinoma is found surrounded by small multiple hyperplastic nodules, recognizable with a lens if not with the naked eye, or even by well-formed adenomata. The more advanced the rectal carcinoma the less likely are associated adenomata to be found, and it seems probable that a carcinoma develops in a rectum which has a predisposition to form adenomata, but that once the malignant tumour becomes dominant, adenomatosis becomes inhibited and existing adenomata retrogress.

This relationship between adenoma and carcinoma is somewhat closely paralleled as between papilloma and epithelioma in the skin of a mouse when it is tarred. In this connection some excellent work has been done by Cramer, Dukes and others, but time will not permit me to enlarge on the subject.

I will show slides illustrating the development of a malignant tumour from an innocent one.

Classification of Cancer of the Rectum.

Very useful work has been done by Dukes on the anatomical classification of rectal tumours, and we are now in a position to assess the future, on this classification, after removal of the growth. We know now that in practically every case lymphatic spread does not take place until the growth has passed through the muscular wall of the rectum, and that so long as this has not occurred, the survivors after radical operation may have a confident expectation of a cure. We know, too, that once the lymphatics have been invaded, the chances of a radical cure by operation are very greatly reduced. These are facts which have now been established by careful pathological investigation, and confirmed by statistics over a large series of cases.

This anatomical classification has been assisted by a histological classification, worked out by Broders and others, which, though presenting difficulties in interpretation, is a definite help in prognosis. Statistical tables worked out on the lines of histological grading conform to, and support, the deductions made from the anatomical classification.

In cases classified as A, *i. e.* those in which the growth has not penetrated through the muscular coats, the mortality for 32 consecutive cases (1927–31) was ***nil***, whereas the mortality for the C cases, *i. e.* those with lymphatic invasion, was 12·7 for 71 consecutive cases. As regards end-results, 15 A cases operated in 1927–29 gave 86% of 3-year cures, whereas 21 C cases gave only 19% of 3-year cures.

Forty-seven patients operated on in 1927–28 were classified histologically. Thirty-two were grades 1 and 2, *i. e.* the low grades, and 15 were grades 3 and 4, or colloid. Twenty-two out of the 32 low grades were alive at the end of three years, *i. e.* 69%, and only 5 out of 15 of the high grades, *i. e.* 33%.

I will illustrate with slides the anatomical and histological classification, and I will show statistical tables of end-results based on both methods of classification.

Colostomy.

I think there is little doubt that the popular prejudice against colostomy dates back to the days of lumbar colostomy and to the earlier days of inguinal colostomy, when no measures were taken to secure a single daily and complete evacuation by irrigation, as is now the rule.

Nowadays, after the patient has washed out his colon in the morning, he puts on his belt and goes about his daily work, quite forgetful of his colostomy.

It is really quite remarkable to-day how little inconvenience the patient with a well-made and well-managed colostomy suffers.

It is of interest to record some mortality figures of colostomy from the records of St. Bartholomew's, and to compare the mortality of lumbar and inguinal colostomy when first practised. The first recorded inguinal colostomy at St. Bartholomew's was in 1887.

1869–78: Lumbar, 46 cases, with 32 deaths, = about 69%.

1879–88: Lumbar, 48 cases, with 22 deaths, = about 45%.

1889–1908: Inguinal, 459 cases, with 118 deaths, = about 25%.

At the present time the mortality for colostomy at St. Bartholomew's for all types of case is 9% (on a 5-year average). This includes all cases of colostomy for acute obstruction.

Diverticulitis and Vesico-colic Fistula.

The sequelæ which result from inflammation in and around diverticula of the colon, such as recto-vesical fistula and stricture, had long been recognized and treated surgically before surgeons realized that there was a common pathological entity, now known as diverticulosis, which was at the back of most of these troubles.

When the pathological and clinical syndrome of inflammation, in association with these pockets, became established, many museum specimens of recto-vesical fistula and stricture of the colon were re-examined, and in many instances a malignant origin, which had been assumed in the past, had to be withdrawn. At the same time an explanation was forthcoming for many cases of supposed inoperable malignant disease in this region, which had been treated by colostomy, and as a result of this alone the patients had subsequently been restored to permanent good health.

There are many early records to be found of recto-vesical fistula, most of which were no doubt due to diverticulitis.

Some two hundred years ago Anthony Fothergill, in reference to this complaint, expressed the view that it might be cured by "a course of Bristol waters and asses' milk".

Dr. Hingeston, in the *Guy's Hospital Reports* (1841), gives an account of a severe case of vesico-colic fistula, and he quotes a writer of the eighteenth century as saying that sometimes air may be mixed with the urine, making it frothy, "like liquor from a cock when the cask is almost empty".

Hingeston says of his unhappy patient: "The form and figure of manhood has departed, the demeanour is no longer erect and the dejected behaviour of the visage betrays the latent disquietude within. Each day is a task of painful and sickening discipline, existence being a burden."

Harrison Cripps, writing on this subject in 1888, gives records of 68 cases of vesico-colic fistula, collected from the literature at that time, of which 2 were traumatic, 9 malignant, 48 inflammatory and 9 uncertain, and refers to the case of a medical man who, unable to endure the pain, ended his life.

The following is a description of a case recorded in *Medical and Philosophical Reports*, 1784, quoted by Cripps:

"A middle-aged lady, in the spring of 1749, became affected with obstinate costiveness. On one occasion, in May, in spite of all the assistance she could obtain, she had no passage either of stool or urine for eight days. During this time she was affected with the most excruciating pain, and her belly swelled to a surprising degree, although she laboured under an almost constant vomiting. After this she discharged some urine, but it was mixed with a considerable quantity of fæces. She then had a stool, and the swelling of her belly fell considerably. After this she lived about three months. During this time she never passed a drop of urine without a mixture of fæces. Another circumstance which deserves to be remarked in the case, is that no sooner did any flatulences move in her stomach or bowels, but they made their way to the bladder. There they have remained till a convenient opportunity, when they have always discharged with a very great noise. Her belly began to swell, and increased slowly till she died, which was in the middle of August. At this time it was greatly distorted. Permission to open the body was refused."

It seems somewhat remarkable that, despite the considerable number of cases of this type of fistula which had been recorded, diverticulosis of the colon, as the principal factor in its causation, should have escaped adequate recognition until the present century.

Although in 1858 Sydney Jones (*Trans. Path. Soc. Lond.*, x, p. 131) reported a case of fistula between bladder and sigmoid, secondary to an inflamed and ulcerated diverticulum of the sigmoid flexure, this important communication, as so often happens, seems to have been lost sight of, and the next published record seems to be that of Graser, who, in 1898, described stricture of the bowel following inflammation of diverticula (*Munch. med. Wochenschr.*, 1899, xlvi, p. 721).

The sausage-shaped tumour so characteristic of chronic fibrosing peri-diverticulitis sometimes goes by the name of Graser's tumour.

Bland-Sutton, in 1903, recognized that concretions from the bowel might perforate into the peritoneal cavity following suppuration in connection with an appendix epiploica.

Rolleston, in 1905, described a case of this disease under the title of "pericolitis sinistra". Moynihan, in 1907, called attention to the mimicry of carcinoma produced by the stenosing tumour of peri-diverticulitis.

It was only very gradually with the help of the opaque meal and enema at this period that the pathology of diverticula in the colon became unfolded. Even to-day we have no certain and exact knowledge as to the cause of the hernial pouches, though the pathology of all that follows, once inflammation has occurred, is fully established.

The frequent examination of the large bowel with the opaque meal and enema now enables this condition to be recognized early, so that the distressing sequelæ of vesico-colic fistula stricture and obstruction are now preventable, if medical treatment is adopted in the early stages.

I have on several occasions been able to cure both recto-vesical fistula and stricture of the colon due to peri-diverticulitis by radical surgery. Nevertheless, this disease is one which calls for more research to prevent, if possible, both the onset of diverticulosis and the inflammatory sequelæ which may or may not follow.

PROCIDENTIA RECTI.

Of the many recent advances in other branches of rectal surgery, it is worth while to refer to the modern treatment of that very distressing complaint, severe procidentia recti, by the operation of recto-sigmoidectomy, which is an operation designed to remove all the slack bowel which can prolapse through the relaxed sphincters.

Although prolapse was treated by amputation as far back as 1887, the operation had not been developed to include removal of all the slack pelvic colon until practised by Miles and others in recent years. In the past the majority of these advanced cases have had to content themselves with some inadequate form of truss. For those who are fit to stand a somewhat severe operation this method is an undoubted blessing.

Many patients whose lives have been hitherto almost unbearable have been made both comfortable and happy. Unhappily, many of those who suffer in this way are aged and infirm, and scarcely fit to undergo a major operation.

MEGACOLON.

Can anyone suppose that the science and art of surgery has attained its zenith, when we observe the wonderful advance that surgery has made in the last few years in the attack on the sympathetic nervous system, a branch of surgery which was hardly thought of a few years ago?

Looking back to the end of the last century, when I started practice, could any one of us have guessed that spasmodic dysmenorrhœa, hydro-ureter, idiopathic megacolon and constipation could be treated and cured by pre-sacral sympathectomy, or even that a paralysed bladder could be made to function; that a chronic gastric ulcer could be made to heal by an attack on the plexus round the cœliac axis; or that Raynaud's disease and crippling arthritis of the upper extremity could be cured by cervico-thoracic sympathectomy?

In 1898, when I was a house surgeon, I watched the late Mr. Lockwood operate on the cervical sympathetic for exophthalmic goitre. This must surely have been one of the earliest operations of this nature, though the method proved to be one of the glittering bubbles that was soon to burst.

It is, indeed, more than probable that in the development of this branch of surgery the pendulum may swing too far. Some of us, with conservative ideas, may hesitate to attack obstinate constipation in this way, until this line of treatment has been more fully tested, but I have little doubt that pre-sacral sympathectomy has come to stay in the treatment of idiopathic megacolon.

I shall show you a specimen of a giant idiopathic mega-sigmoid which filled the abdomen, and which I resected shortly before the valuable work of Hunter and Royle on sympathectomy became generally known.

The patient was a woman in the forties, who had suffered from toxic constipation all her life, and had been chaffed, since childhood days, about her distended abdomen. The specimen removed was 22 in. long and 18 in. in maximum circumference. The result of this operation was entirely successful. The altered appearance which followed was not only a great joy to the patient, but resulted in wedlock not long after.

Such excellent results have followed pre-sacral sympathectomy that the more risky procedure of resection is no longer called for.

I now show you slides to illustrate sympathectomy for this disease. The radiograms were taken from a case successfully operated on by Mr. Naunton Morgan, my chief assistant at St. Bartholomew's, and an Assistant Surgeon at St. Mark's.

CONCLUSION.

I cannot close my address without a passing tribute to my colleagues at St. Mark's, and especially to Dr. Dukes, the pathologist. It is largely due to their initiative and progressive work that I have been able to retail and illustrate some of the recent advances in rectal surgery.

I do not doubt that before another quarter of a century has passed new vistas will have been opened up, and much that I have extolled may have become antiquated.

I wish that I could gaze through the crystal and see what I am sure some of you will see, the task of the rectal surgeon simplified, when the cancer problem has been solved.

Percival Pott, towards the end of the eighteenth century, in looking back after fifty years of practice, said*:

"Many and great are the improvements which the chirurgical art has received in the last fifty years; and many thanks are due to those who have contributed to them; but when we reflect how much still remains to be done, it should rather excite our industry than inflame our vanity."

If we consider all the advantages that we have to-day, the many and varied aids to diagnosis, the wonderful improvements in methods of anæsthesia, the excellent facilities for blood transfusion, etc., and if we consider the disadvantages under which our immediate predecessors laboured, masters as they were in clinical diagnosis, before the introduction of X-rays, the sigmoidoscope, gas and oxygen, basal narcotics, spinal anæsthesia and the like, we have need of much humility in assessing the value of the progress we have made in rectal surgery.

C. GORDON-WATSON.

* As recently quoted in the *St. Bartholomew's Hospital Reports.*

COARCTATION OF THE AORTA.

ALTHOUGH coarctation of the aorta may be properly described as a rare condition, it occurs with sufficient frequency to merit brief consideration, especially as it is occasionally the cause of errors in diagnosis—errors which lead at times to the adoption of methods of active treatment, unnecessary, unsuitable or even harmful to the patient.

The condition results from a maldevelopment of the aortic arch, and the essential feature is a constriction of the lumen of the vessel, with consequent obstruction to the circulation of blood below the level of the lesion. In a recent review, Evans (1) has dealt fully with the subject, and he recognizes six distinct varieties. For clinical purposes it is not necessary to discuss these in detail, and two main groups may be distinguished—that in which there are other gross developmental abnormalities in the heart, characterized by a patent ductus arteriosus, stenosis of the arch and hypoplasia of the proximal portion of the aorta, and that in which the ductus arteriosus is closed, the constriction is situated slightly distal to its junction with the aorta, and the left ventricle and the proximal portion of the aorta are hypertrophied. The former type presents many of the features commonly regarded as being characteristic of congenital heart disease, such as cyanosis, clubbing of the fingers and a variety of cardiac murmurs, and the existence of the cardiac abnormality is obvious in childhood. The latter type, to which attention will be confined in this paper, is not as a rule recognizable as a clinical entity on superficial examination, and it is in this group of cases that difficulties in diagnosis may arise.

The existence of gross obstruction to the flow of blood in the aorta is attended by compensatory vascular changes which have for their object the maintenance of the circulation in the lower half of the body, and the resultant anatomical vascular changes may be divided into three groups :

1. *Changes in the heart.*—Conditions in which there is interference with the freedom of the circulation almost invariably produce secondary changes in the heart, and the most obvious clinical indication of the circulatory disturbance is the discovery of a cardiac abnormality ; care must therefore be taken, in all cases in which the heart is found to be in any way abnormal, to discover the exact ætiological cause for the condition.

In the case of coarctation of the aorta, there is circulatory obstruction sufficiently near the heart to produce obvious left ventricular hypertrophy as a rule ; in addition, there may be a systolic præcordial murmur best heard either in the mitral area or at the aortic base, and this murmur does not necessarily indicate organic valvular disease. Occasionally other congenital abnormalities, such as patent septum, may also be present, in which case further murmurs may be heard. The only constant and characteristic change is the hypertrophy of the left ventricle.

2. *Changes in the circulation proximal to the obstruction.*—From the fact that the obstruction is situated distal to the point of origin of the left subclavian artery, it follows that the systolic blood-pressure will be raised in the brachial artery on both sides, and the tension in severe cases is usually found to exceed 200 mm. Hg. The collateral circulation is carried on chiefly through the branches of the subclavian arteries which anastomose with the intercostal arteries, and so supply the descending thoracic aorta with blood. This collateral circulation is usually stressed in the text-books as an important point in diagnosis, and the impression is conveyed that the enlarged vessels are visible and obvious. Except in thin patients this is not the case, and the vascular abnormality is only noted when the thickened and dilated arteries are discovered on palpation. Failure to note the presence of the collateral circulation is the usual cause of failure to recognize the existence of the condition.

The collateral circulation is present, and should be sought, in three places :

(*a*) In the front of the chest, where greatly enlarged internal mammary arteries may be felt.

(*b*) In the axillæ, where the lateral thoracic arteries are easily found. A systolic murmur can often be heard in these vessels, and this murmur, when heard in the *right* axilla, far removed from the heart-sounds, is very suggestive of enlargement of this vessel.

(*c*) In the region of the scapulæ, where a leash of vessels may be found very constantly running down the vertebral border of the bone.

The presence of a collateral circulation of this type is almost pathognomonic of coarctation, but unfortunately its existence is usually overlooked, chiefly because it is not commonly realized that the enlarged vessels must be sought by palpation in the majority of cases. The condition is so rare that it would obviously be carrying precaution too far to institute a search for a collateral circulation in every case of enlargement of the left ventricle, with high blood-pressure, and fortunately this is not necessary for, as will be shown later, the presence of the condition may be suspected as a result of other observations, as a result of which the search may be carried out in suitable cases.

3. *Changes in the circulation distal to the obstruction.*—The major part of the circulation in the body has to be

carried by the anastomotic series of vessels described above, and it is surprising how efficiently it is maintained, in view of the obvious difficulties. The thoracic and abdominal aorta and their larger branches are hypoplastic, and the pressure of the blood circulating in them is necessarily low, and it is this fact which provides a clue to the diagnosis. Pulsation cannot be felt in the abdominal aorta, and the femoral arteries are difficult or impossible to locate. The blood-pressure measured in the legs rarely registers more than 100 mm. Hg., and it is frequently impossible to obtain a satisfactory reading.

A few years ago Rösler (2) pointed out that the anastomotic vessels which join the intercostal arteries cause the formation of notches in the lower borders of the ribs, and that these can be demonstrated in skiagrams. These notches appear to be pathognomonic, and their presence may be regarded as proof of the presence of coarctation. It is sometimes stated that they result from the pressure of enlarged internal mammary arteries, but this is clearly impossible, as these vessels lie against costal cartilage, and no shadow is cast on the film. The notches are certainly due to the presence of large vessels which connect the scapular and lateral thoracic with the intercostal arteries. A radiogram of one of the cases to be described here is reproduced, and the notches are clearly seen.

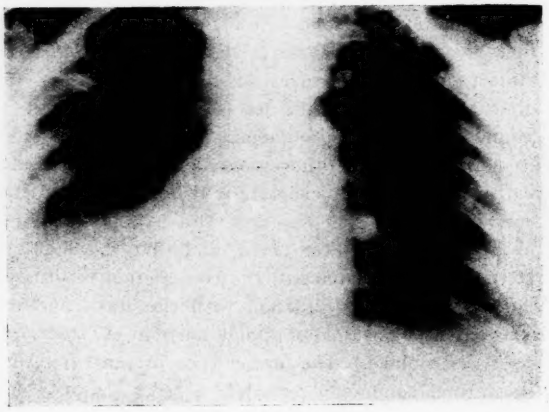
The following three cases have come under the observation of the writer during the past two years, and they illustrate the difficulties which may be associated with the diagnosis of the condition:

CASE 1.—M. T—, female, æt. 33, married, no pregnancies. Admitted to the Royal Chest Hospital under the joint care of Dr. A. W. Stott and the writer on October 17th, 1932, suffering from acute bronchitis and heart failure. At the age of 18 months she had attended a children's hospital, where a diagnosis of congenital heart disease was made; at the age of 12 she had two attacks of rheumatic fever, since which time she had never been strong, and aortic and mitral valve disease had gradually developed.

The family history was interesting, as her mother was stated to have heart trouble, her father developed valvular disease during the war, and one brother died from acute pericarditis.

Physical examination revealed a greatly enlarged heart, with the characteristic murmurs of aortic regurgitation and mitral stenosis. The blood-pressure was 270/80, an extremely high pulse pressure. It was not until the radiogram demonstrated the presence of notches on the ribs that the underlying coarctation was suspected. Further search then showed the palpably enlarged anastomotic vessels, there was no pulsation in the abdominal aorta and the femoral pulse was very feeble; the systolic blood-pressure in the legs was never more than 100 mm. Hg. Although the case might have been correctly diagnosed on clinical grounds, the picture was so obscured by the superimposed rheumatic valvular disease that failure to recognize the nature of the congenital lesion was almost inevitable.

CASE 2.—C. E. B—, male, æt. 20. The patient was sent to the Out-Patient Department of the Royal Chest Hospital as a case of suspected phthisis on September 8th, 1930. He was complaining of moderate præcordial pain on exertion, which interfered with his work as a railway porter, and of slight shortness of breath on exertion. He had had pneumonia in infancy, and was subject to bronchitis. On examination he appeared to be a healthy-looking youth, and the lungs were found to be normal. The heart was enlarged to the left, however, and a faint and variable mid-diastolic murmur was heard at the apex. The blood-pressure was 200/110 mm. Hg. He was admitted for investigation under the care of the writer, and his renal functions were found to be quite normal. The final diagnosis was "essential hypertension", and his tonsils, which were septic, were removed in the hope that they contained the focus responsible for the trouble. No change was noticeable, and attempts to reduce the blood-pressure were fortunately unsuccessful. It was only two years later, when his original X-ray films were being scrutinized, and the notches were noticed for the first time, that the true nature of the condition was realized. Subsequent examination revealed the vascular phenomena which have been already described; the blood-pressure in the legs was too low to be accurately registered. The reason for the mis-diagnosis in this case was the fact that the vascular phenomena, although present, were not obvious on superficial examination, and the error could easily have been avoided by measuring the blood-pressure in the legs, or even by palpating the femoral pulse.



RADIOGRAM SHOWING NOTCHES IN RIBS.

CASE 3.—K. J—, female, æt. 34, married, four previous pregnancies. This patient was known to have "heart trouble" as a child, and had always been a little short of breath on exertion and subject to occasional swelling of the ankles. In November, 1933, when five months pregnant, she had complained of headaches, swelling of the legs and scanty urine; these symptoms improved with rest in bed. At this time it was noticed that the blood-pressure was over 200 mm. Hg., and that a moderate degree of albuminuria was present. On January 6th, 1934, a syncopal attack occurred, during which time the blood-pressure fell to 115 systolic. When examined by the writer, on January 13th, she had been resting in bed for a week, and the œdema and albuminuria had entirely disappeared. The left ventricle was found to be much enlarged, and a diffuse systolic murmur was present over the præcordia; systolic murmurs were also heard in the right axilla and over the left scapula. The blood-pressure at this time was 245/160. The question seemed to be whether the symptoms were due to a pregnancy toxæmia or to chronic renal disease, and both of these conditions appeared to be ruled out by the rapid recovery with rest and by the normal urine, which was found to be well concentrated. Accordingly search was made to exclude other causes of hypertension. There was no evidence to suggest the presence of any of the common forms of acquired heart disease, and it was noted that the femoral pulse was impalpable. It was not possible to obtain any blood-pressure reading in either leg, and this settled the diagnosis. Subsequent search revealed the anastomotic vessels in their usual situations, and the diagnosis was placed beyond question by the X-ray, reproduced here, which was taken after the patient had been admitted to Charity Ward under the care of Dr. Beattie and Dr. Wilfred Shaw, to whom I am indebted for permission to publish the case.

In each of these cases the diagnosis was not made until adult life was reached, and in the first two cases the essential clue was derived from the radiogram of

the chest. In Case 1 the exact diagnosis is of little moment, as the patient presents the clinical picture of advanced rheumatic heart disease, and the presence of the coarctation only makes a bad prognosis slightly worse. In Case 2, however, failure to make the correct diagnosis led to the adoption of an inappropriate line of treatment, for, in an attempt to eliminate focal sepsis, the tonsils were sacrificed and prolonged rest was enjoined, together with the administration of drugs designed to lower the blood-pressure. It was only when the true nature of the condition was realized and the patient was permitted to lead a normal life of moderate activity that he regained his health. In Case 3 the establishment of the correct diagnosis was a strong indication that the symptoms resulted from heart failure, and not from chronic nephritis nor from a toxæmia of pregnancy, as had been suspected.

The course pursued by the cases which reach adult life appears to be relatively benign, although heart-failure or cerebral hæmorrhage are apt to occur, and rheumatic infection of the heart is not uncommon as a complication. A number of cases are on record in which a bacterial infection has become grafted upon the damaged area, giving rise to a condition essentially similar to septic endocarditis; one such case was reported by Anderson (3), in this journal, some years ago.

Treatment of the condition is symptomatic only, and patients should be allowed to lead a normal life within the limits of their cardiac efficiency. More harm is probably caused by injudicious treatment of these cases than would result if they were left alone.

COMMENT.

Coarctation of the aorta is rarely diagnosed correctly, and it is probable that many cases are overlooked. The diagnosis can be made with confidence in cases of the type described here. In every case in which there is a high brachial blood-pressure, *for which no adequate cause can be found*, the blood-pressure should also be measured in the legs. If there be a marked discrepancy, with low blood-pressure in the legs, it is very probable that coarctation is the cause, and its presence may be confirmed by the demonstration, in the skiagram, of the characteristic notches in the lower borders of the ribs.

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JAMES MAXWELL.

THE IMPORTANCE OF A FOLLOW-UP DEPARTMENT IN THE CLINICAL INVESTIGATION OF DISEASE.

AT present there is a feeling in this and other countries that the time is ripe for an advance to be made along the cancer front. The call to more aggressive warfare has recently been sounded by Prof. G. E. Gask (1), who has also outlined the strategy of the fight. At a recent discussion in the Section of Surgery at the Royal Society of Medicine there was a unanimous opinion that, while much good work has been accomplished, there is an urgent necessity for expansion, and that a co-ordinating mechanism should be established to bring together all the work on cancer which is being done in this country. It was also felt that more vigorous clinical research should be pursued. Time is essential in order that this ideal state of things may be established, but a survey of the front reveals several weak places where immediate progress may be made. Before it is possible to establish a perfect organization to co-ordinate cancer work on a national scale, it is essential that those units to be co-ordinated be as perfect as possible. There is room for improvement in the organization used for cancer work in many of our hospitals, and it is proposed to discuss two important aspects of this work, namely, the Follow-up Department and case-records.

A HOSPITAL FOLLOW-UP DEPARTMENT.

The governing bodies of several hospitals in this country have realized the importance of ascertaining the ultimate value of the work carried out in the wards, and have established efficient Follow-up Departments. In many hospitals, however, there is no such organization. This is a serious omission in our hospital system, and a matter for consideration by the governing bodies concerned. I wish to call attention to the value of a Follow-up Department.

(A) *Value to the Patient.*

It has been found that the majority of patients appreciate being called up for periodic examination, and value the sense of security thus given to them. In patients treated for cancer it is essential to examine them at short intervals so that recurrences may be dealt with immediately. The surgeon who undertakes to treat a patient for cancer should be prepared to keep him under observation for at least five years. Regarding patients with goitre, as a result of continued observation they are readmitted for further treatment as their

condition demands it. Many patients with innocent papillomata of the urinary bladder have recurrences which are noted at the periodic cystoscopy examinations in the Follow-up Department. It is possible that a revision of our conception of the incidence of gastro-jejunal and jejunal ulceration following anastomotic operations on the stomach would be necessary if such patients were followed up on a large scale.

(B) *Value to the Surgeon.*

In the Follow-up Department we learn the real value of our treatment. We see our successes, and are made conscious of our failures and profit by our mistakes. Insufficient attention has been paid to surgery in the light of a Follow-up Department. At the present time we have but little knowledge of the exact value of our methods of treatment in many groups of cases.

The Follow-up Department is adaptable for post-graduate teaching. Courses are given by this means in the Post-Graduate School of Radiotherapy, centralized in the Mount Vernon Hospital and the Radium Institute, showing the end-results of radiotherapy. Medical practitioners must be able to give a prognosis, and this is often of more importance to a patient and his friends than diagnosis. It is important for students prior to qualification to study the end-results of certain methods of treatment, and there is scope for the development of this side of our teaching.

(C) *Value to the Profession.*

It is important for us to know the present position of the various methods of treatment employed in certain conditions, and this is of special importance in cancer. We want information on a large scale of the relative values of excisional surgery and irradiation in the treatment of cancer of the breast and buccal cavity, and whether or not better results are obtained with combined surgical and radiological methods.

In 1922 the Governors of St. Bartholomew's Hospital formed a Follow-up Department to inquire, amongst other things, into the end-results of the treatment of cancer in certain sites. Accurate case-records of all patients have been kept, and the value of the work is enhanced because very few patients have been lost sight of. A great deal of valuable information has been collected, and is now being analysed and worked up. The first Report from the Follow-up Department (2) has been published concerning the end-results of the treatment of cancer of the breast and cancer of the buccal cavity. In this way we learn the real value of each method of treatment employed in the Hospital, which leads to the further development of those methods which are giving the best results. In the present stage of our knowledge of the treatment of cancer it is a mistake to persist in the multiplicity of the methods of treatment, since this only tends to spread confusion, and to nullify attempts to reach definite conclusions of their relative values. If each hospital used one or two valuable methods of treatment for certain types of cancer cases we would quickly reach a conclusion of the best method or methods available to us at present. I therefore make a plea for a scheme of work as outlined above, to be embarked on by other hospitals, and that their experiences be published. In this way we shall learn the value of cancer treatment on a national scale, and will be able to make plans for further development.

The National Radium Commission, in their Annual Report (3), describe a similar plan which is being executed to evaluate the results of radium therapy on a national scale. In this instance case-records are being carefully compiled on a uniform sheet, and patients followed up for a minimum period of five years after treatment. The correlation of all this material must prove of the greatest value.

If it is necessary to compare these national results of radium therapy, where can be found a series of comparable magnitude treated by excisional surgery? Prof. Gask, in his recent lecture, said: "It is, I think, a reproach to our hospital system that an accurate knowledge based on a large number of figures is not easily available."

It may be mentioned that Follow-up Departments have been working for many years at the Radiumhemmet in Stockholm, and at the Mayo Clinic in America. The National Radium Commission, when establishing national centres, insisted on the formation of an efficient Follow-up Department.

THE PLANNING OF A FOLLOW-UP DEPARTMENT.

It is proposed to give some account of the Department at St. Bartholomew's Hospital, in the hope that it may help others who are contemplating the formation of a similar department.

Scope of the Investigation.

(*a*) Cancer of the breast: Every patient treated in the Hospital for cancer of the breast is followed up after discharge. A large series of cases has been collected, and we are now able to compare the survival rates in comparable cases resulting from excisional surgery and interstitial irradiation. These remarks are more or less applicable to the following:

(*b*) Cancer of the buccal cavity.

(*c*) Cancer of the pharynx and larynx.

(*d*) Cancer of the stomach.
(*e*) Selected cases of cancer of the rectum.
(*f*) Cancer of the urinary bladder.
(*g*) Cancer of the uterus.
(*h*) Cancer of the thyroid gland.
(*i*) Papilloma of the urinary bladder.

The Department is not entirely devoted to the study of malignant disease, and the following are being investigated:

(*j*) Non-malignant ulceration of the stomach and duodenum. A survey is being made of the end-results of the medical treatment employed in the Hospital wards, and of the various surgical procedures adopted. Other issues are being considered, such as the incidence of gastro-jejunal and jejunal ulceration after anastomotic operations.

(*k*) Toxic goitre: A large series of patients are being followed up who have received either medical or surgical treatment in order to evaluate our present methods.

(*l*) Diabetes mellitus: We have learnt the importance of keeping patients under careful observation. A check is kept on the blood-sugar, the diet taken, and the amount of insulin used.

Case-Records.

While the patient is in the ward a complete record is made of the condition and treatment carried out. The ward notes are stamped as coming under the Follow-up Scheme. All ward notes are forwarded to the Central Registry after the patients are discharged, and the follow-up scheme notes are singled out and sent to the Follow-up Department.

Method of Registry in the Follow-up Department, and the Calling up of Patients for Examination.

An index card, showing the name and address of the patient, the name of the physician or surgeon, the disease, the date of discharge from hospital and the operation performed is completed for each patient coming under the follow-up scheme. The important columns on this index card are: "Date of notification," requesting attendance in the Department, and "Date of examination" which subsequently takes place. Numbers of patients have the same "date of notification"; thus groups of patients to be sent for at the same time are formed, and their cards are filed together. In practice it is found advisable to file these index cards according to the month in which the patients are notified to attend. A note is sent to each patient requesting attendance in the Follow-up Department on a certain date and time. If the patient is unable to come, the doctor in attendance often sends a report on the condition and progress and these are entered in the notes. In the event of death the date and cause of death are recorded in the notes so that the records are complete in every way.

Case-Sheets used in the Follow-up Department.

The ward notes are kept in folios, and when these arrive in the Follow-up Department the Follow-up Case-sheet is inserted. Special case-sheets have been designed for the sake of uniformity, and to ensure that nothing is omitted which is of importance in the goitre and diabetic groups.

This system of case-sheets could be extended with advantage to include other groups of cases. An entry is made regarding the patient's condition at each examination by the surgeon.

FAILURE TO RESPOND FOR EXAMINATION.

The success of a Follow-up Department lies in the ability to maintain contact with the patient. If a large number of patients are lost sight of the value of the collected material is considerably reduced. In our Department very few patients have been lost sight of amongst the thousands investigated. This achievement is entirely due to Miss E. J. Ball, who is responsible for this aspect of the work. We are maintaining contact with patients all over the world, and it is interesting to hear of their progress. If a patient fails to come for examination no effort is spared to find the reason and to establish contact again. Various methods are used, such as the help of the doctor in charge of the patient at home, or various nursing and welfare associations.

METHODS OF SEEING PATIENTS IN THE FOLLOW-UP DEPARTMENT.

The ideal method is the formation of Follow-up Clinics, in which patients suffering from a given disease are seen together. In certain instances it is advantageous for physician and surgeon to work together in these clinics. We have formed clinics for patients treated for goitre, and gastric and duodenal ulceration, in which physician and surgeon work together. There are Follow-up Clinics for diabetes mellitus, cancer of the breast, buccal cavity, rectum and uterus. In these clinics the physician or surgeon who was responsible for treatment examines the patient and records his observations. It is important that the surgeon should see the patient at each visit, especially after radium treatment, in order to decide if the growth is regressing or advancing.

It is not always possible for a physician or surgeon to devote time for attendance at special Follow-up Clinics. In these cases we have found it satisfactory for such patients to be seen at the Out-Patient Clinic.

CORRELATION OF THE MATERIAL IN THE FOLLOW-UP DEPARTMENT.

This aspect of the work should be under the control of a medical man—a surgeon for the surgical work and a physician for the medical work. An index is kept of every patient registered in the Follow-up Department. The individual index card shows the diagnosis, including the type and stage of disease, with the histological data and the method of treatment adopted. Details are recorded of each examination made in the Follow-up Department. Patients treated with radium are entered on the Summary Cards issued by the National Radium Commission. If death occurs, the date and cause are noted, together with details of any post-mortem examination. Index cards are filed according to the disease and site of disease. By this means a complete and accessible record is available for every patient under the follow-up scheme. In these indices there is a wealth of detail, which is analysed, correlated and published from time to time. The yearly results of various methods of treatment in certain diseases are readily available for discussion by physicians and surgeons concerned, and may be modified or abandoned according to the results achieved. In this Hospital charts are kept showing the yearly position of patients treated by excisional surgery and radium for cancer of the breast and buccal cavity.

A SCHEME WHICH MAY BE USED IN THE FORMATION OF A FOLLOW-UP DEPARTMENT.

1. Decision regarding which groups of cases are to be followed up.
2. Clerical Staff: One clerk can deal with 400 patients; should have experience of out-patient routine.
3. Follow-up case-sheets to be drawn up.
4. Index for the registry of each patient and the collection into groups according to the month in which they will be asked to attend for examination.
5. Request to patient for attendance—a short standard letter drawn up.
6. If patient is unable to attend, the local doctor is communicated with.
7. If patient is lost sight of, efforts to trace made through nursing institutions or welfare organizations.
8. Follow-up clinics held by each physician and surgeon—record made on case-sheet and date fixed for next examination.
9. Correlation of clinical material, statistical tables kept for groups of patients and results published.
10. The cost of a Follow-up Department is reasonably small.

CANCER CASE-RECORDS.

If we are to attain to a better understanding of the clinical side of the cancer problem, it is essential that adequate case-records of patients be kept. To keep these records in a haphazard way is useless. No clinical detail, however small, should be omitted from the notes. It would be an advance of importance if a uniform case-sheet could be drawn up for the notes of every cancer patient. This would ensure that an adequate number of patients all carefully worked out and recorded would be available for a worker on clinical problems in cancer. In the future it may be possible to use such records on a national scale and produce results of the greatest importance.

A scheme similar to the above has been launched by the National Radium Commission, and is working very satisfactorily. The Commission has issued case-sheets of a comprehensive nature, and these are being carefully compiled for patients treated with radium throughout England and Scotland. This is one of the greatest clinical investigations ever attempted, and I cite it to show that my thesis is practicable. If some concerted effort is to be made to investigate and report on the present methods in the treatment of cancer, it is essential that we start by keeping uniform and adequate case-records.

CONCLUSIONS.

1. It is desirable for every hospital to possess a Follow-up Department, in view of the value to the patient, physician, surgeon and the profession as a whole.
2. That the collection and correlation of the experiences gained in the Follow-up Department will lead to a better understanding of the value of present methods of treatment, especially in cancer.
3. The importance of establishing a uniform system of keeping case-records is discussed.

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R. W. RAVEN.

SOME APHORHYTHMS.

Prelude.

A mind, inclined to criticism
Of nebulous scholasticism,
And prolix flow
Of words, that spell bombasticism,
Might exercise its cynicism
Condensing sense.

(*An aphorhythm.*)

The Circulatory System.

Those subjects, dubbed with optimism,
" High backache due to rheumatism ",
May slowly blow,
With each successive paroxysm,
A sacculated aneurysm,
And go below.

(*An aphorhythm.*)

The Alimentary System.

When bowels vow with dogmatism
To cease their active mechanism,
'Tis wise to ply
Cathartics with some heroism,
And shelter from the cataclysm,
Between a screen.

(*An aphorhythm.*)

The Neuroses.

A painter, trained to futurism,
A sudden fit of vorticism
May throw; and so,
By diagnosing meningism,
Or homicidal strychninism,
The careless err.

(*An aphorhythm.*)

The Endocrine Organs.

The pundits, stunned with modernism,
Their dream-clouds of metabolism
Distil; all ill,
From hyperparathyroidism
To sexual antagonism,
Would fain explain.

(*An aphorhythm.*)

Diseases of Children.

The oblique orb of mongolism
Some cerebral anomalism
Declares; and there's
No doubt the wretched organism,
Afflicted through such atavism,
Remains insane.

(*An aphorhythm.*)

Special Subjects.

Short sight, long sight, astigmatism,
Need merely an appropriate prism.
The hoarse, and sore
Of throat, one treats with pragmatism,
Coll. alk., some simple gargarism,
Will fill the bill.

(*An aphorhythm.*)

The Unqualified Practitioner.

The quacks, who practise galvanism,
And " nature cures ", and mesmerism,
Despite the right
And proper meed of ostracism,
Bestowed upon such solecism,
Purloin much coin.

(*An aphorhythm.*)

Finale.

So many men their catechism
Attack, with misplaced egotism;
A flair Queen Square
Is apt to view with pessimism.
The token of its scepticism
Is pink, I think.

(*An aphorhythm.*)

A. R.

THE CURRICULUM: ANOTHER PROTEST.

I ENCLOSE my subscription to the Journal, and from the honourable position thus attained I am anxious to add my small quota of criticism to the " heavies " which have already gone over. The subject worrying me is the present system of medical education, which, I feel very keenly, leaves much to be desired.

There are, as we learn in youth, sins of omission and commission, and I indict the present *régime* under both headings.

In the limpid innocence of my finals I honestly believed what little I knew of the text-books. I believed, for example, that a mosquito with any pretensions to a decent upbringing kept to within twenty feet or so of the ground, and faded away in cold weather. It's a lie. And I say it with as great a gusto as Browning ever brought to the business.

I have yet to find the " ceiling " of a hungry mosquito. I proclaim it from bitter experience with the thermometer near freezing and with lumps upon my brow.

Again, what do I know about devils? Nothing, or very little. We just were not taught about them. And yet I have had a—well, quite a lot to do with devils since I qualified. Not once but several times I have been asked, as a presumably educated man, about devils and their *rôle* in the medical cosmos. I did not know. I just looked silly.

After all for some odd two thousand years the best theological opinion has consistently upheld the theory and been heartily supported by the laity, while it is not so long since we changed our own coat in the matter.

Armed with that omniscience proper to a year's job as resident, I started out for foreign parts and bumped into my first devil in the middle of the Red Sea.

I was called to see a stoker with a temperature of 104°, on whom five others were sitting, with the praiseworthy idea of preventing his going over the side. Much ice and half a grain of morphia affected him about as much as a mosquito bite, and it was three hours before he quietened down. I was asked, very naturally, what brand of demon was responsible for the unseemly hubbub. And answer came there none.

My shipmates were better instructed in these matters. During the previous voyage the chief engineer had had trouble with one of the bunkers. There was a devil in it, and the men refused to work it. In the same position I might have adopted the feeble evasion of the gentleman who, faced with a giraffe for the first time, said, " There ain't no such thing "—a line of conduct which would have led nowhere. Not so the Chief. Faced with *un fait accompli* he assembled the harassed natives and dealt with the matter on a basis of sound logic.

He pointed out that she was a new ship, less than three years off the stocks. Consequently that while there might be a devil, it could only be a very young one, and that if a lot of hefty, full-grown and adjectival stokers were scared of a miserable little frightened little three years old devil, they ought to be damn well ashamed of themselves. They were. Why was I ignorant of all this?

At home the respective merits of pulv. ipecac. co. and tr. camph. co. may be nicely balanced to the satisfaction of the physician and, conceivably, the patient.

To find the common denominator in a sura of the Koran, neatly inscribed from the region of the seventh cervical vertebra to the fourth lumbar and quinini sulphus gr. x *t.d.s.* is, through lack of adequate teaching, far more difficult.

This leads us to the inadequacy in ethics and general deportment. Is it really the thing, even with the best intentions, to discount a colleague's honest efforts, and clap one's profane chest-piece all over his sacred handiwork?

We fail not only in behaviour, but command of language, excepting technical idiom, which is a more or less close preserve, only to be poached on by the more impertinent laity.

Again to etch in these omissions from my own sad past. On visiting a venerable and courteous old sheikh I was gracefully informed in flowery Arabic that, in addition to my natural beauty, I was also the most blindingly overpowering manifestation of concentrated intelligence that had ever loomed on his horizon, and that, *inshallâ'h*, I would undoubtedly heal his belly-ache.

Now I feel that a sound curriculum would have equipped me with a few phrases adequate to convey that in my eyes my host was the sun, moon, stars and the oyster's eyelash, instead of leaving me to retreat feebly on " Not at all ", or " Very good of you to say so ".

In mitigation I confess that this facet of my character has seldom been forced on my attention at home, where truth is bandied about in a manner repugnant to the oriental, who, regarding it rightly as a pearl of great price, treasures it for select and nicely judged occasions, and deprecates its being scattered to the casual passer-by, who, for all he knows, may be quite unworthy to receive it.

For mistakes in diagnosis and treatment I blame only myself and neglected opportunities. And here I must digress somewhat from my theme to introduce Abdul, because, in due course, I want to arrive at the case of Abdul's niece.

On my arrival to take over a job of work Abdul was attached to me for intelligence, topography, and as surgery attendant. He was also able to drive a car, but in this one matter I decided to relieve him. The basic principle of driving in the East, or more correctly, of being driven, is that you get there fast—if you get there.

Abdul hailed from N. Africa, and in a life of thirty-two years had graced many vocations. The story of how Adbul won the war, detailed in graphic flashes during leisure moments, gave me quite a new grasp on that event. Other pastimes included professional wrestling and hospital orderly duty.

His chief reason for forsaking the Tricolour appeared to be the surmise that as a native subject in wartime he might be asked to do a great deal of arduous work for a ridiculously inadequate remuneration.

His soul, however, remained essentially Gallic, and the French are known to be a cynical and sceptic race

except in some few matters of moment, like cooking. Nor did he strive to rid himself of a certain tolerant contempt for the effete customs of a monarchy. As he explained to me one day, " In this country, Sir, everyone bow down in front of kings and big men. One man have big name. Everyone make great fuss for him. My country not like that. My country I meet king in café. He say, ' Good evening Abdul. How you ? Have a drink ? ' I say, ' Good evening King. All right. Thank you.' He not speak to me. Then I not give damn for him."

Despite this slight suggestion of *lèse-majesté* he was on the best of terms with the law, and if left for five minutes would always be found deep in conversation, preferably with the police or else with prisoners, or indeed anyone capable of speech, and, more essential still, of hearing. He explained his popularity with the Force quite simply.

Before his arrival under the reflected halo of Æsculapius, and during his gladiatorial days, he sometimes celebrated his victories in a manner worthy of a conqueror, if not perhaps of a devout Muslim. On these occasions the police used to try to run him in. His routine reply was to throw them over his shoulder, preferably the left, on to their heads, thus laying the foundations of many enduring friendships.

That he ran a large and lucrative practice in his spare time I became convinced. I could not imagine such a gifted personality wasting its genius on the desert air. So when he mentioned casually one morning that his niece seemed ill, I accepted the delicate compliment and said I would have a look at her.

She had diarrhœa with a headache, raised temperature and comparatively slow pulse. The temperature rose higher on the second and again on the third day. Having set my course for a presumptive typhoid, I sat back to wait on events. They arrived in the morning with Abdul, who looked a trifle tired.

He attributed this to sitting up most of the night taking his niece's pulse and temperature hourly, subsequent to her wolfing, on the previous evening, the hen which was cooking for the family supper while the family back was turned—a matter of ten or fifteen minutes.

I am glad, for the patient's sake, to report that, by the morning, the temperature, pulse and respirations had dropped to normal, where they remained thereafter. Had I the mental grasp and professional acumen of a H——r, I would doubtless have perceived factors in that case indicating that the specific for a syndrome with headache, abdominal disturbance, stair-case temperature and slow pulse was one large roast hen, *quantum libet, alno jejuna.*

As it was I slavishly followed the text-books and came a cropper.

Abdul, a perfect gentleman, beyond at times assuring me of the good health of all his family, mentioned the regrettable incident no more.

Let me close on a more pleasant note, and having finished my critical survey, give thanks for that wisdom and skill which I absorbed and transmitted in faithful service.

If at times I have fallen by the wayside, also I have savoured the gratitude and thanks of those I helped.

One pleasant if somewhat querulous old native gentleman of sixty-five was much worried over a double inguinal hernia of long duration to which he ascribed, among other things, a certain weakening of his libido. At some trouble I had a suitable truss forwarded from several hundred miles away. On its arrival I laid my patient prone and carefully adjusted the appliance. On seeing him some days later my labour was well rewarded by the glow of appreciation on his face and his words of heartfelt gratitude. On only one small point had we any divergence of opinion. I discovered that he preferred the truss reversed, the pads fitting snugly beneath the costal margins. D. D. DALE.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* COVENTRY.

Played at Winchmore Hill on January 20th, 1934. Won, 6—0.

Bart.'s were without three of the regular team, and did extremely well to beat a Coventry team who were at full strength with the exception of Harold Wheatley, who was with the English team at Cardiff as a reserve forward.

Play in the first twenty minutes was chiefly mid-field, and it was obvious that there was not going to be much in the match one way or the other. It was surprising to see our forwards in the tight scrums not only holding their own, but actually pushing a Coventry pack which must have been a great deal heavier.

For a time play settled in the Coventry half, and from a scrum Wilson broke through on the blind side, and gave the ball to Nel, who by hard running, touched down for a try before two Coventry defenders could bundle him into the corner flag. The kick fell short. Bart.'s continued to have the better of the game, and after numerous efforts to kick goals from difficult positions, Nel kicked a good goal from near the touch-line (6—0). Soon afterwards followed the best movement in the match: starting in our own half with Kingdon the ball was carried almost to the Coventry line *vid* Fairlie-Clarke, Mundy, Hunt and Capper. Just before half-time Coventry made their first real bid for a score, which was thwarted when a score seemed certain by Mundy and Jackson.

In the second half Coventry were much more dangerous, and getting most of the ball from the tight and the loose were continuously testing our defence, which was so faultless that Dransfield was never left with a man to tackle. The latter's fielding and kicking were excellent. Gilbert and Harriman were the most dangerous Coventry backs. The only time we looked like scoring in the second half was

when Youngman took the ball from our "25" to the Coventry "25" in a good solo run.

The pack individually and as a whole were good and extremely well led by Capper.

Team.—C. M. Dransfield (*back*); J. G. Youngman, G. H. Fairlie-Clarke, R. M. Kirkwood, J. G. Nel (*three-quarters*); J. R. Kingdon, J. D. Wilson (*halves*); R. S. Hunt, P. D. Swinstead, D. W. Moynagh, E. E. Harris, J. M. Jackson, F. H. Masina, W. M. Capper, R. Mundy (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* OLD ALLEYNIANS.

Played at Dulwich on January 27th. Lost, 19—3.

On a muddy ground the Old Alleynians had much the better of a rather scrambling game and beat the Hospital by 2 goals, 3 tries to 1 penalty goal. In every department the Old Alleynians proved themselves superior, and the heavy ground seemed to have far more effect in slowing down the Hospital than it did the home team.

Play at first was even, and after ten minutes Nel kicked a well-judged penalty goal, to give Bart.'s the lead (3—0). From this time onwards the Old Alleynians controlled the play, and it was not long before Heppenstall levelled the score with an unconverted try from a line-out, which showed the Bart.'s defence badly at fault. The Old Alleynian forwards dominated the game and Stark scored a try, which was converted by Heppenstall. Soon afterwards Kerr scored and Pettifer converted.

In the second half the Old Alleynians continued to be on top, and adapted themselves to the heavy conditions much more than did Bart.'s, and Davies, in scoring the best try of the match, hopelessly outpaced more than one Bart.'s defender. Before the end Pettifer added another unconverted try, and the final score of 19—3 in no way flattered the Old Alleynians.

INTER-HOSPITALS CUP.

1st Round.

ST. BARTHOLOMEW'S HOSPITAL *v.* KING'S COLLEGE HOSPITAL.

Played at Richmond on Tuesday, February 6th. Won, 18—0.

Not even staunch loyalty could allay a certain feeling of dread that St. Bartholomew's might succumb to a weaker hospital in the earliest stage of the cup-ties. King's had beaten a side by which Bart.'s were defeated two games before and therefore had every ground for optimism.

The first ten minutes, however, proved to be the only time that the opponents appeared in any way likely to be formidable. Play was continually in mid-field, when a loose pass from a King's centre was picked up at full speed by Nel, giving the defence no hope. Morison converted. A short while later a similar wild pass, lobbed high into the air, gave Nel a second opportunity. This time, however, he was caught in running toward the goal, and passed to Darmady. A second rapid pass left Youngman to score a fine try, Morison converting.

Though Bart.'s were now dominant, there was still much to be desired. The three-quarters, though excellent in defence, rarely made ground in their movements, many of which were spoilt by faulty passing and uncertain handling. Kirkwood and Fairlie-Clark produced some fine low tackles. The forwards, with the usual two or three exceptions, seemed listless and lethargic, and several times the ball was seen to be surrounded by the King's colours without a single Bart.'s jersey near.

Half-time came with no addition to the score-board (10—0). Play continued more or less in the King's half of mid-field. Two further tries were added, the first a brilliant cut-through by Kingdon, and the second by Capper after a characteristic battering-ram charge through the scrum. Morison converted one of these. King's very rarely looked like scoring, in spite of the efforts of a bustling pack, and the game ended in an easy victory for Bart.'s, but one which raised no very sanguine hopes of the fate of the Cup. Much polishing of even the most rudimentary arts seemed to be required to present any sort of opposition to the formidable rivals in the other half of the draw.

Team.—C. R. Morison (*back*); J. G. Youngman, G. A. Fairlie-Clark, R. M. Kirkwood, J. G. Nel (*three-quarters*); J. R. Kingdon, J. D. Wilson (*halves*); E. M. Darmady, R. S. Hunt, P. D. Swinstead, J. M. Jackson, E. E. Harris, J. C. Newbold, W. M. Capper, R. Mundy (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* PONTYPOOL.

Played at Winchmore Hill on February 10th. Lost, 6—11.

With Darmady, Capper and Hunt absent, a depleted Hospital pack, though game and hard-working, found the virile and pugnacious Welsh forwards too heavy and experienced, and failing to hold an early advantage, due largely to the fine hooking of K. D. Moynagh, making his *début* against a Welsh International hooker, were latterly swept off their feet and compelled to play the type of game by which Pontypool, of recent years, have become notorious.

Gaining the ball in the early scrums, the Hospital set up a strong attack and soon went ahead from a fine penalty goal by Morison. Pontypool, however, settled down to play a strong forward game, and were soon in Bart.'s territory—a position which they occupied almost throughout the game, from which they were forced only by long and accurate kicks from Morison and an occasional rush from Mundy and Newbold, both of whom were always as quick in attack as they were ubiquitous in defence.

Pontypool shortly took the lead by a try from Atkins, which Allen converted, but were prevented from scoring again by a good tackle by Youngman.

The sixth penalty out of the twelve awarded to the Hospital during the game found Morison able, from just inside the half-way line, to kick a second goal and give Bart.'s the lead—a circumstance to which Pontypool responded with more vigour than skill, and by sheer weight carried the game to the Hospital "25".

There followed a period of attack by forwards and backs, wave after wave of which, breaking on the reefs of the Hospital defence, rippled on to the shores of barren endeavour, and it was not until the last five minutes, when, with Pirie injured and the backs disorganized, Pontypool managed to snatch a victory by two tries, neither of which was converted.

Wilson, behind beaten forwards, lived to tell the tale, and Kingdon with few chances contrived to get his three-quarters moving from impossible places and cut through, in one instance, with genius. Morison's sagacity, like the widow's cruse, was inexhaustible, while the whole team, rarely in a position to attack, distinguished themselves by their extremely sound and stubborn defence.

Team.—C. R. Morison (*back*); J. G. Youngman, R. M. Kirkwood, A. H. Pirie, J. G. Nel (*three-quarters*); J. R. Kingdon, J. D. Wilson (*halves*); F. H. Masina, K. D. Moynagh, P. D. Swinstead, J. M. Jackson, E. E. Harris, J. C. Newbold, J. A. V. Nicoll, R. Mundy (*forwards*).

HOCKEY CLUB.

ST. BARTHOLOMEW'S HOSPITAL *v.* HARLESDEN.

Played on Saturday, January 20th. Won, 1—0.

The game was played on an exceedingly muddy pitch, which rendered good hockey almost impossible. The mid-field standard of play, however, was fairly good, with Winter showing to advantage at centre-half.

Play started with Bart.'s attacking, and in spite of hard, first-time clearances from Harlesden, our forwards had very much the better of the first ten minutes or so. Soon Martin scored with a hard shot from the edge of the circle (1—0), and though Bart.'s pretty constantly kept up the pressure, the score was to stand thus for the rest of the game. Our defence at times was tested, especially once, when Crosse saved repeatedly with brilliance, but though Oliver was often too slow in effecting his clearances, our goal was never again in real danger.

The second half was much of a repetition of the first. Good individual runs were seen from Hinds-Howell and both wings, but without score.

Team.—J. M. Crosse (*goal*); W. A. Oliver, A. D. Messent (*backs*); P. Jayes, J. R. Winter, B. Thorne-Thorne (*halves*); P. G. Hill, A. Hinds-Howell, K. W. Martin, J. Blackburn, J. M. Lockett (*forwards*).

Replay 1st Round Inter-Hospital Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* ROYAL DENTAL AND CHARING CROSS HOSPITALS.

Played on Tuesday, January 23rd. Won, 4—3.

The previous week, after twenty minutes' extra play, the Hospital had failed to beat the Royal Dental and Charing Cross Hospitals.

The replay was fought out on an iron-hard, frost-bound pitch with visibility much restricted through fog and yet was remarkably exciting. Blackburn opened the scoring with a good flick-shot (1—0)

and play seemed to favour Bart.'s. Our opponents were playing very hard, and their inside left, Webb, was always a danger. It was from one of his lightning "break-aways" that they equalized (1—1), quickly to follow with another goal from the same source (1—2).

Until late in the second half Bart.'s looked a beaten team, and it was not till three minutes before time that Jayes equalized from the edge of the circle (2—2).

Thus once again "extra time" had to be played. Very quickly, however, after the change-over, Lockett cut in to score with a push-shot (3—2), and was followed by an effort from Hinds-Howell to put us two goals ahead (4—2).

There was very little more time to go, but Charing Cross were making great efforts to draw level. A goal was scored (4—3), and almost immediately, with an open goal to shoot into, one of their forwards hesitated, giving Messent time to get back and effect a brilliantly cool save with the tip of his stick. Pressure was relieved, and Bart.'s had won by 4 goals to 3.

Team.—J. M. Crosse (*goal*); W. A. Oliver, A. D. Messent (*backs*); P. Jayes, J. R. Winter, B. Thorne-Thorne (*halves*); P. G. Hill, A. Hinds-Howell, K. W. Martin, J. Blackburn, J. M. Lockett (*forwards*).

2nd Round Inter-Hospital Cup.

ST. BARTHOLOMEW'S HOSPITAL *v.* UNIVERSITY COLLEGE HOSPITAL.

Played on Wednesday, January 31st. Won, 6—1.

A thoroughly enjoyable game, played on a pitch which, though soft, gave a very good surface. Bart.'s, though at first having to fight hard, soon proved themselves the superior.

The first goal was scored through a good piece of combination. Lockett, running through, passed back to Blackburn, whose shot was followed up and rushed through by Martin (1—0). Crosse, however, had some bad luck in goal, and the score was answered fairly quickly by U.C.H. (1—1).

From thence onwards Bart.'s had much their own way, Blackburn scoring three times with beautiful push-shots, Hinds-Howell once with a lovely drive and Martin once again (6—1). Mention must, however, be made of the truly remarkable goal-keeping of the U.C.H. "goalie"; without his brilliance there would have been many more goals scored.

Team.—J. M. Crosse (*goal*); W. A. Oliver, A. D. Messent (*backs*); P. Jayes, J. R. Winter, B. Thorne-Thorne (*halves*); P. G. Hill, A. Hinds-Howell, K. W. Martin, J. Blackburn, J. M. Lockett (*forwards*).

ST. BARTHOLOMEW'S HOSPITAL *v.* R.M.C. SANDHURST.

Played on Saturday, February 3rd. Won, 8—2.

This proved to be one of the most enjoyable games of the season, and though Bart.'s were definitely the better side, the game was keenly fought and never void of interest.

Our forwards played possibly their best game this season and showed themselves both enterprising and effective. Lockett opened the scoring from the left and was quickly followed by Martin (2—0). The Sandhurst forwards were, however, fast, and at times severely taxed Oliver and Messent, who were, however, steady and reliable. Several beautiful first-time shots were instrumental, though, in Sandhurst equalizing (2—2).

Little can be said of the rest of the game except that it abated nothing in vigour. Martin, who must have enjoyed the afternoon's work, added four more goals, Hinds-Howell and Blackburn bringing the total up to eight.

Team.—J. M. Crosse (*goal*); W. A. Oliver, A. D. Messent (*backs*); P. Jayes, J. R. Winter, B. Thorne-Thorne (*halves*); P. J. Hill, A. Hinds-Howell, K. W. Martin, J. Blackburn, J. M. Lockett (*forwards*).

BOXING CLUB.

A match was held with University College, London, on Friday, January 19th, in the Gymnasium, Charterhouse Square. Bart.'s won by 5 bouts to 2.

At middle-weight L. R. Taylor put up a very good fight against D. H. A. Christie-Murray, whose very excellent defence just enabled him to gain the decision. Taylor is a much improved boxer and has an excellent upper-cut, which would, however, be used to much greater advantage if used less often. In the second contest at middle-weight J. Perrott gave a very spirited and hard-hitting display, and gained a decisive victory over F. Walch.

In the welters J. J. Slowe beat J. D. James, who retired at the end of the second round.

Both the light-weight contests ended in the first round. M. W. Harvey took several hard punches in the solar plexus, which proved to be his weak spot; R. D. Hernaman-Johnson gained a very quick victory by an excellent right hook.

In the bantams C. F. Bose, a newcomer to the Boxing Club, won as he liked against a rather inexperienced opponent. A. Butt was given quite a hard fight at fly-weight, but won with a fair margin of points.

Fly-weight: A. Butt (Bart.'s) beat F. H. Vieira (U.C.) on points.

Bantams: C. F. Bose (Bart.'s) beat H. G. Thompson (U.C.) on points.

Lights: (1) I. F. Gregory (U.C.) beat M. W. Harvey (Bart.'s) in first round. (2) R. D. Hernaman-Johnson (Bart.'s) beat R. Roach (U.C.) in first round.

Welters: J. J. Slowe (Bart.'s) beat J. D. James (U.C.) in second round.

Middles: (1) D. H. A. Christie-Murray (U.C.) beat L. R. Taylor (Bart.'s) on points. (2) J. Perrott (Bart.'s) beat F. Walch (U.C.) on points.

The United Hospitals have held fixtures this term with Oxford University and London University; the following have been selected from Bart.'s for the United Hospitals teams: R. Kirkwood, J. H. Armstrong, L. R. Taylor, A. Butt, C. F. Bose and J. J. Slowe.

The United Hospitals Boxing Competition is being held on Monday, March 12th, at the Ring, Blackfriars; tickets will be obtainable from the Hon. Secretary at the Hospital.

RIFLE CLUB.

Since the notice in January the Club has kept up its high standard of performance. Forty-two matches have been shot since the beginning of the season and thirty-two of them have been won.

The following are details of more recent matches and league tables to date:

Inter-Hospital Cup League.

(Shoulder-to-shoulder Matches.)

ST. BARTHOLOMEW'S HOSPITAL *v.* ST. THOMAS'S HOSPITAL.

January 23rd; home. St. Bart.'s, 588; St. Thomas's, 577. Won by 11 points.

Scores: G. C. Brentnall 99, J. E. Underwood 99, J. S. Bailey 98, D. O. Davies 98, G. E. Soden 98, J. T. H. Butt 96.

February 9th; away. St. Bart.'s, 573; St. Thomas's, 571. Won by 2 points.

Scores: J. S. Bailey 98, W. A. Owen 98, J. Dalziel 96, J. E. Underwood 96, J. T. H. Butt 94, B. P. Armstrong 91.

Bart.'s are at the head of this League and are, so far, unbeaten in Inter-Hospital matches.

Engineers' Cup League.

Matches shot.	Won.	Lost.	Drawn.	Points.
10	9	1	0	18

Bart.'s remain at the top of this League with a lead of 2 points over Imperial College.

Of the three matches shot since Christmas all have been won.

City of London Rifle League.

	Matches shot.	Won.	Lost.	Drawn.	Points.
"*A*" *Team:*	13	9	4	0	18
"*B*" *Team*	13	8	5	0	16

The "A" Team are 3rd in Division 7.

The "B" Team 5th in Division 13.

The Club have to congratulate D. O. Davies on scoring two "possibles" in match shoots and K. W. Donald on scoring one.

UNITED HOSPITALS HARE AND HOUNDS.

MATCH *v.* TRINITY COLLEGE, DUBLIN, AND THAMES HARE AND HOUNDS.

This year the match against Dublin University was held as a three-sided fixture with Thames H. & H. over the course of about 6½ miles at Roehampton. Thames were too good for us this time,

but we avenged ourselves of last year's defeat by Dublin by a comfortable margin of 10 points.

Over the first mile the lead continually changed hands, until Kensit (Thames) and French (Dublin) went ahead, followed closely by Taylor (Thames) and Williams (Hospitals). The field then opened out, and Price (Hospitals), who had, as usual, made an easy start, went ahead with Taylor, beating him with a strong finish in 37 min. 42 sec.

There was considerable fog during the latter part of the run, which caused some difficulty in following the course, one Dublin and one Hospitals man getting lost on Wimbledon Common.

Order of finishing.—(1) A. K. Price (H.), 37 min. 42 sec.; (2) A. E. Taylor (T.); (3) J. Hewson (D.); (4) J. T. Race (T.); (5) K. O. Black (H.); (6) G. T. Honniball (T.) and M. F. Kensit (T.), equal; (8) J. T. Given (D.).

Result.—(1) Thames H. & H., 43 points; (2) U.H.H.H., 53 points; (3) T.C.D., 63 points.

CORRESPONDENCE.

PSYCHOLOGY AND THE CURRICULUM.

To the Editor, 'St. Bartholomew's Hospital Journal'.

DEAR SIR,—I assume that the greater percentage of students passing through a teaching hospital eventually settle down in general practice, and it is in general practice that one meets with such a large proportion of cases that are either of a purely psychological nature, or may be partly organic, with a marked psychological element superadded. Is this fact not a very sound reason for the inclusion in the students' curriculum of some teaching in the study and application of this ever-increasing and important subject?

I, like so many (I fancy), would not hesitate to admit that one's knowledge of this subject on becoming qualified was conspicuous by its absence, and yet, looking back now, I, for one, would have welcomed some tuition in this subject to have made one's task easier and more successful in the handling of such cases. I am afraid an oft-repeated phrase of the budding doctor to his patient (provided, of course, he has not discovered some obscure and rare disease!)—"You must pull yourself together; there is nothing whatever the matter with you"—is but a sign that part of his training has been omitted, and that omission is the study of psychology. It is not the patient, perhaps, that should pull himself together—it may even be the doctor!

In this type of case, however ridiculous and absurd the assertions of these patients may appear in the absence of organic disease, there is, I venture to suggest, some hidden and obscure reason for their claims, and it is futile to tell a patient to pull himself together; it is for the doctor to probe and pull out the offending element, imaginary though apparently it may appear, and however tedious and exacting the task may prove—and it will, indeed, often prove so. A danger signal is, however, called for in the inclusion of this subject lest a ready remedy is available, to ascribe too readily as psychological those cases which prove not clear at the onset—this is indeed a real danger—but provided the dictum that every case coming before one is accepted as a potentially organic one, I think this danger would soon become negligible, and in any case a little knowledge of psychological methods in an effort to relieve these sufferers would, indeed, be preferable to saying, "You must pull yourself together; there is nothing whatever the matter with you"—an advantage both to the patient himself and to the doctor, but an advantage of a slightly different nature!

Yours truly,

62, Forest Road,
Dalston, E. 8.

DUDLEY H. COCKELL.

UNMASTICATED FOOD IN FÆCES.

To the Editor, 'St. Bartholomew's Hospital Journal'.

SIR,—On February 13th last there was a post-mortem in this Hospital on a man whose death was due to the impaction of large lumps of veal and ham pie in the lower end of his œsophagus. I hope I may make this striking example an excuse for drawing the attention of readers of the JOURNAL to the frequency of a habit, which in this case led to the patient's death. The lower classes are not brought up on Mr. Gladstone's principle of thirty-two bites to every mouthful; their technique at meal-times approximates more closely to that of my dog, who would dispose, for example, of a Catering Company sausage, or its equivalent bulk in even tougher material, after one or two cursory movements of the jaw, occupying only a few seconds. My evidence for this is not the patient observation of the habits of the poor in their own homes, or in the wards of the Hospital, but the condition of their excreta as seen in the laboratory. In stools sent to be examined for parasites or for abnormal bacteria, it is common to find that the only abnormal feature of whatever kind is the presence of large and numerous lumps of food which are not merely undigested, but unmasticated. It is of some practical interest that many kinds of vegetable material in this form are easily mistaken for masses of mucus. Careful and prolonged washing reveals what must be a large proportion of a preceding meal intact and almost in its original form. Doubtless some of these patients are excused by very imperfect teeth for what they do with their food (one of the worst examples I ever saw was in a woman admitted for severe vomiting a year after a gastro-enterostomy, who had no teeth at all); others are merely ignorant or lazy. But I am not concerned so much with why they do it, or with the appalling waste it represents, as with its possible effects on the alimentary tract. It is a suggestive fact that such specimens not infrequently come from patients labelled "colitis". Is it not possible that common functional disorders of the stomach and bowel, if not ultimately conditions of a graver nature, may be due to the constant swallowing of these unmanageable lumps of food?

I venture to commend this suggestion to those whom it may concern. The existence of unmasticated food in the fæces has a positive significance unfortunately not shared by the presence of such odd bacteria as we often cultivate from them in the laboratory, and is more readily ascertainable. If a tap, well protected in a sink, were enclosed in a spherical sieve in which the stool is placed, a few minutes' running of the tap would yield all the junk which the specimen contained in a recognizable and fairly clean condition. A study conducted with this simple apparatus might well reveal a significant relationship between the average size of the component parts of the residue, or its total bulk, and the frequency of certain gastro-intestinal disorders.

I am, Sir,
Yours faithfully,

Pathological Laboratory,
St. Bartholomew's Hospital,
London, E.C. 1;
February 23rd, 1934.

LAWRENCE P. GARROD.

REVIEWS.

RADIOTHERAPY IN THE DISEASES OF WOMEN. By MALCOLM DONALDSON. (Hodder & Stoughton, 1933.) Price 7*s.* 6*d.*

In the introduction to this book the author states that he has written it in the hope of conveying an unbiased opinion on the value of radiotherapy in gynæcology, and again, in the author's words, an attempt has been made to describe shortly and in simple language, for the benefit of the practitioner and the student, the present position of radiography in gynæcology. There is no doubt that the text of the book thoroughly fulfils the objects for which it has been written.

There are one hundred and twenty-one pages, which are divided into three sections, dealing with (1) elementary physics of irradiation, the biological action of radium and the methods of application; (2) cancer, ætiology, early diagnosis, education of the public, etc. Following this division, the varieties of malignant disease of the uterus are discussed in detail and the various methods of radiological treatment are given. A most interesting part of this section is that devoted to the results of treatment of carcinoma of the cervix by radium and deep X-rays in the recognized centres throughout the world. The author states a strong and yet unbiased case for the treatment of carcinoma of the cervix by radiological methods only.

The third section deals with benign conditions which are amenable to radiotherapy, and a small but interesting chapter on the subject of the dangers of radiotherapy ends the book.

This book is written in an interesting manner, and although the

text is simple to understand, there are many references and descriptions of the recent work that may bear some relationship to the subject under review.

A SHORT HISTORY OF SOME COMMON DISEASES BY DIVERS AUTHORS. Edited by W. R. BETT. (Humphrey Milford.) Pp. 211. Price 10s. 6d. net.

Though the majority of young men are at heart hero-worshippers, it is equally true that the modern tendency to regard intellectual pursuits as bad form may be powerful enough to smother the instinctive reverence for great men and their works. The study of history is commonly regarded with disfavour because it is considered "high-brow", and the average medical student shuns the history of medicine in particular because he feels that any day it may be added to the burden of the curriculum and become a subject for examination.

As an antidote to this feeling of dislike for the history of medicine, the book edited by Dr. Bett, whose articles on historical subjects are so well known to readers of the JOURNAL, may be heartily recommended. To those students and practitioners—and may we not add teachers?—who are not ashamed of their love for the history of medicine, the book is as valuable as it is delightful.

Dr. Bett has contributed only one chapter, that on appendicitis, as his own share, and he is to be congratulated on his good fortune in having obtained the co-operation of such distinguished collaborators to write chapters on fifteen other common diseases. With one astonishing exception they are all so full of information, and are written for the most part in such an entertaining style, that to pick and choose between them becomes a matter merely of personal taste. If one had to single out certain chapters for special note, they might well be those by Mr. Harold Burrows on Malignant Disease, by Dr. James Collier on Epilepsy, by Sir D'Arcy Power on Venereal Diseases, by Prof. J. A. Nixon on Bright's Disease, and especially that on Tuberculosis by Prof. John Fraser. We feel that his chapter is of peculiar value to students, because in it he gives much more than the mere story of how tuberculous disease has been identified—he fires the imagination and rouses us almost to a state of excitement as "we follow the stirring of consciousness, the accumulation of knowledge over a thousand years, the sifting in the light of reason and logic; and, when the wheat is winnowed from the chaff, there stands forth the true conception of things as they are—disease and antidote". Such is his conception of the study of the history of medicine, and his enthusiasm is infectious!

Dr. Bett is to be congratulated upon this original venture in medical literature, and we would urge all students of medicine to make a habit of referring to his book in order to discover how much of what we call our knowledge of these common diseases we owe to the discoveries of the past century and how much to antiquity.

COMBINED TEXTBOOK OF OBSTETRICS AND GYNÆCOLOGY. By Prof. J. M. MONRO KERR, J. HAIG FERGUSON, JAMES YOUNG and Prof. JAMES HENDRY, with contributions from Prof. CHARLES MCNEIL and J. DUNCAN WHITE. Second edition. (Edinburgh: E. & S. Livingstone, 1933.) Pp. xii + 1100. 505 illustrations. Price 35s. net.

Obstetrics and gynæcology are subjects with so much in common that it is surprising that, in spite of their combination in the examinations, the majority of textbooks deal with each separately. When this volume was first published in 1923 it was welcomed as clarifying and condensing the subject as well as stressing the complete interdependence of the two subjects. Ten years has been rather too long a time to wait for revision when all medical knowledge has advanced so much. There is therefore much new material incorporated in this edition.

The book is divided into twelve parts. The first, having nearly a hundred pages, describes anatomy and physiology. Normal and abnormal pregnancy, labour and puerperium are then dealt with systematically, and a new chapter is added by Prof. Monro Kerr on puerperal mortality, being an excellent and informative review of the subject and a synopsis of his larger work. A "connecting chapter" links this portion with the remainder devoted to gynæcology. It contains a description of the present state of endocrinology in relation to the subject. The chapters are arranged for the most part on an anatomical basis. The part on operative surgery is very clear, and is profusely illustrated. The book is concluded by a new part on radiology by Dr. Duncan White. The index is a full one and well arranged.

The publishers have spared no pains in the production of the volume, for the type is clear and the illustrations excellent, of every kind from photographs to diagrams. In spite of the many additions there has only been an increase of one hundred pages.

The book will prove a useful one to students as being a comprehensive and readable exposition of the subject, representing the most modern ideas of science and practice.

CLINICAL CONTRACEPTION. By GLADYS M. COX, M.B., B.S. (William Heinemann, Ltd., 1933.) Price 7s. 6d.

The public in increasing numbers is asking the doctor for sane advice with regard to birth-control measures. This growing demand for knowledge of the subject makes it necessary for all medically qualified persons to be able to give the necessary advice when consulted, and to show familiarity with the modern methods employed, so that the best variety of contraceptive is used in individual cases.

Dr. Cox has produced a book which will be a most valuable aid for all who, at any time, may be asked to advise on the question of contraception. The subject is most exhaustively dealt with in a practical manner, and the controversial side of the matter has purposely been left out.

Although the many and numerous methods of contraception which may be employed are discussed in detail, with reasons given for and against their use, Dr. Cox states clearly which variety she considers should be used in individual cases, and after the chapters on the various types of contraceptive, there follow two chapters on contraception for the normal woman and contraception for the abnormal woman.

The final chapter deals with contraception and the Public Health Service, and an appendix gives a list of birth-control clinics, and a list of contraceptives with their manufacturing firms and agents.

This volume should be read by all who are likely to be called upon to give advice on contraceptive measures.

RECENT ADDITIONS TO LIBRARY.

ANATOMY.

BUCHANAN: *Manual of Anatomy.* Fifth edition.
BUCHANAN: *Dissection Guide.*
FABRICIUS: *De Venarum Ostiolis.* Facsimile edition, with introduction, translation and notes by K. J. Franklin, D.M.
FRAZER: *Anatomy of the Human Skeleton.* Third edition.
HARRIS: *Bone Growth in Health and Disease.*
MASSIE: *Surgical Anatomy.* Second edition.

BACTERIOLOGY.

HEWLETT and MCINTOSH: *Handbook of Bacteriology.* Ninth edition.

BIO-CHEMISTRY.

COLE: *Practical Physiological Chemistry.* Ninth edition.
PARSONS: *Fundamentals of Bio-chemistry.* Fourth edition.

BIOGRAPHY.

MARTIN: *The Joy of Living; An Autobiography.*

DISEASES OF CHILDREN.

HOLT and HOWLAND: *Diseases of Infancy and Childhood.* Third edition.
PARSONS and BARLING: *Diseases of Infancy and Childhood.*
THOMSON: *The Clinical Study and Treatment of Sick Children.* Fifth edition.

EMBRYOLOGY.

KEITH: *Human Embryology and Morphology.* Fifth edition.

ENDOCRINOLOGY.

BROSTER and VINES: *The Adrenal Cortex.*
CAMERON: *Recent Advances in Endocrinology.*

HEART.

LEWIS: *Clinical Disorders of the Heart Beat.* Seventh edition.

HISTORY OF MEDICINE.

SIGERIST: *Great Doctors: A Biographical History of Medicine.*

MATERIA MEDICA.

BRUCE and DILLING: *Materia Medica and Therapeutics.*

MEDICINE.

BEAUMONT and DODDS: *Recent Advances in Medicine.* Seventh edition.
CECIL: *Textbook of Medicine.* Third edition.
PRICE: *Textbook of the Practice of Medicine.* Fourth edition.
SAVILL: *A System of Clinical Medicine.* Ninth edition.

NERVOUS SYSTEM.

RANSOM: *Anatomy of the Nervous System.*
RUSSELL BRAIN: *Diseases of the Nervous System.*

OPHTHALMOLOGY.

YELD: *A Thesis on Accommodation in the Human Eye.*

ORTHOPÆDICS.

MERCER: *Orthopædic Surgery.*

PATHOLOGY.

BOYD: *Surgical Pathology.* Third edition.
TOPLEY: *An Outline of Immunity.*
WILLIS: *The Spread of Tumours in the Human Body.*

PHYSIOLOGY.

HALLIBURTON and MCDOWALL: *Handbook of Human Physiology.* Thirty-third edition.
STARLING: *Principles of Human Physiology.* Sixth edition.

SURGERY.

GASK and ROSS: *The Surgery of the Sympathetic Nervous System.*
KANAVEL: *Infections of the Hand.* Sixth edition.
ROSE and CARLESS: *Manual of Surgery.* Fourteenth edition.

TREATMENT.

DONALDSON: *Radiotherapy in the Diseases of Women.*
HUTCHISON: *Elements of Medical Treatment.* Second edition.
LAWRENCE: *The Diabetic Life.* Seventh edition.

TUBERCULOSIS.

MORRISTON DAVIES: *Pulmonary Tuberculosis: Medical and Surgical Treatment.*

EXAMINATIONS, ETC.

Conjoint Examination Board.

Final Examination, January, 1934.

The following students have completed the Examinations for the Diplomas of **M.R.C.S., L.R.C.P.,** and have had the Diplomas conferred on them:

Bailey, J. S., Benison, R. L., Bintcliffe, E. W., Danino, E. A., Dharmasena, C. B., Edward, D. G. ff., Gale, H. E. D., George, C. A., Hatton, P. L. S., Hindley, G. T., Johnson, D. J., Jones, E. G., Jones, F. A., Kingdon, J. R., Pirie, A. H., Powell, J. D., Rassim, H. S., Reavell, D. C., Sablin, N. S., Sheehan, D. J., Smith, M. C. L., Stephens, K. F., Sutton, R. J. C.

APPOINTMENTS.

SMITH, Sir RUDOLPH HAMPDEN, Bart., F.R.C.S., appointed Honorary Consulting Surgeon, Torbay Hospital, Torquay (having retired from the active Honorary Staff).

STEPHENS, D., M.R.C.S., L.R.C.P., appointed Assistant Medical Officer, Oldchurch Hospital, Romford (Essex County Council).

TAYLOR, HERMON, M.Chir.(Cantab.), F.R.C.S., appointed First Assistant to Mr. A. J. Walton at the London Hospital.

CHANGES OF ADDRESS.

BUCHLER, E., 57, Bedford Road, S.W. 4. (Tel. Brixton 6366.)
MORGAN, R. G., 24, Stow Park Avenue, Newport, Mon.
WROTH, C., 45, Southernhay West, Exeter. (Tel. 3548.)

BIRTHS.

CARNEGIE BROWN.—On February 6th, 1934, to Ella, the wife of Dr. A. Carnegie Brown, of Ripon—a son.

DARMADY.—On February 1st, 1934, at 20, Devonshire Place, W. 1, to Mary (*née* Bird), wife of Dr. E. M. Darmady—a son.

GALLOP.—On February 16th, 1934, at Northfield, Elmstead Lane, Bickley, Kent, to Doris Ruth (*née* Gwatkin), wife of Dr. Edward Gallop—a daughter.

HOBDAY.—On February 18th, 1934, at 32A, Trebovir Road, Earl's Court, to Sczerina Néomi (*née* Radford), wife of Dr. F. T. J. Hobday—a son.

HOLMES.—On February 14th, 1934, at 57, Albert Road, Southport, to Phyllis, wife of John Holmes, M.B., M.R.C.P.—a daughter.

RAINEY.—On February 7th, 1934, at 149, Dereham Road, Norwich, to Margaret and Philip Rainey—a son.

MARRIAGES.

ECCLES—KEENE.—On February 15th, 1934, at the Register Office, Westminster, George Tolcher Eccles, M.A., M.B., B.Ch.(Cantab.), of Hove, to Gladys Elizabeth, elder daughter of Mr. and Mrs. A. Keene, of Whistow and Ashton-under-Lyne.

STEPHENS—FREDERICK.—On February 21st, 1934, at Holy Trinity Church, Brompton, Deri Stephens, M.R.C.S., L.R.C.P., to Kathleen Patricia Frederick, only daughter of the late Dr. E. G. Frederick.

DEATHS.

BRIGGS.—On February 1st, 1934, at Premier House, Gregory Boulevard, Nottingham, Florence Emily, the devoted wife of Dr. J. A. Oswald Briggs.

CAVE.—On February 16th, 1934, at 16, Circus, Bath, Edward John Cave, M.D., F.R.C.P., aged 74.

CHITTENDEN.—On February 7th, 1934, Thomas Hillier Chittenden, M.D., M.R.C.P., Barrister-at-Law, Lt.-Col. R.A.M.C. (retired), aged 78.

DUNN.—On February 7th, 1934, suddenly, at Tiverton, Devon, Spencer Graeme Dunn, F.R.C.S., B.Sc., etc., of 16, Adamson Road, N.W. 3.

MACKENZIE.—On February 10th, 1934, at sea on S.S. "Duchess of Richmond", Colin Mackenzie, O.B.E., M.A., F.R.C.S., of 11, Mornington Villas, Bradford.

SCOTT.—On February 26th, 1934, Leonard Rex Bodley, beloved son of Dr. L. Bodley Scott, of Blandford, Dorset, aged 22.

THOMAS.—On February 12th, 1934, in a nursing home in London, Dr. Harold S. Thomas, of London Road, Portsmouth, aged 58.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., *at the Hospital.*

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: National* 4444.